Print Form

Name of Patient: _____

PRIMARY INSURANCE

Name of Insured: _____ _____ _____ Relationship to patient: _____
Last Name First Name MI

Insured Birthdate: ____ / _____ / _____ Insured Soc. Sec.# _____ - _____ - _____ Home Phone: (____) _____-_____

Address (if different from patient):_____ _____ _____ _____
Address City State Zip Code

Insured Employed by: _____ Occupation: _____ Bus. Phone: (____) _____-_____

Business Address: _____ _____ _____ _____
Address City State Zip Code

Insurance Company: _____ Phone: (____) _____-_____

Contract #: _____ Group #: _____ Subscriber #: _____

Is patient covered by additional insurance? ☐ yes / ☐ no

SECONDARY INSURANCE

Name of Insured: _____ _____ _____ Relationship to patient: _____
Last Name First Name MI

Insured Birthdate: ____ / _____ / _____ Insured Soc. Sec.# _____ - _____ - _____ Home Phone: (____) _____-_____

Address (if different from patient):_____ _____ _____ _____
Address City State Zip Code

Insured Employed by: _____ Occupation: _____ Bus. Phone: (____) _____-_____

Business Address: _____ _____ _____ _____
Address City State Zip Code

Insurance Company: _____ Phone: (____) _____-_____

Contract #: _____ Group #: _____ Subscriber #: _____

Is the patient covered by a third or more additional insurances? ☐ yes / ☐ no

I authorize release of any information relating to evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that any treatment plans estimating insurance benefits are estimates only and may be different from the actual plan payment. I also understand that I am responsible for any charges not covered by my insurance(s).

_____ Date: _____/___/_____
Signature