

We do not accept insurance but we will gladly fill out a form for you. Please fill in the following information:

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE

ADDITIONAL INSURANCE

Name of Insured _____

Name of Insured _____

Relationship to Patient _____

Relationship to Patient _____

Insured's Birthday _____

Insured's Birthday _____

Social Security # _____

Social Security # _____

Employer _____

Employer _____

Employer Address _____

Employer Address _____

Employer Phone # _____

Employer Phone # _____

Insurance Company _____

Insurance Company _____

Insurance Address _____

Insurance Address _____

Group # _____

Group # _____

Employee/Cert. # _____

Employee/Cert. # _____

Ins. Co. Phone # _____

Ins. Co. Phone # _____

Deductible _____

Deductible _____

Max. Annual Benefit _____

Max. Annual Benefit _____

AUTHORIZATION

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers.

Signature of patient or parent if patient is a minor

Date