PATIENT BILLING & DENTAL INSURANCE INFORMATION: DATE_____

PATIENT'S NAME_____SS#_____

ADDRESS_____ DATE OF BIRTH_____

CITY, STATE_____ZIP CODE_____

HOME PH_____WK PH_____CELL PH_____

REFERRING DENTIST_____

NAME OF PERSON TO RECEIVE BILL:_____

ADDRESS:_____

PHONE NUMBER_____SS#_____

PRIMARY DENTAL INSURANCE COMPANY
NAME OF POLICY HOLDER_____

POLICY, ID, OR SUBSCRIBER #_____GROUP #_____

NAME OF INS COMPANY_____

ADDRESS TO SEND CLAIMS_____

CITY, STATE_____ZIP CODE_____

POLICY HOLDER'S DATE OF BIRTH_____SS#_____

NAME OF EMPLOYER_____

EMPLOYER'S ADDRESS_____

CITY, STATE_____ZIP CODE_____

SECONDARY DENTAL INSURANCE COMPANY
NAME OF POLICY HOLDER_____

POLICY #_____GROUP#_____GROUP NAME_____

NAME OF COMPANY_____

ADDRESS TO SEND CLAIMS_____

CITY, STATE_____ZIP CODE_____

NAME OF EMPLOYER_____

EMPLOYER'S ADDRESS_____

PATIENT'S RELATIONSHIP TO POLICY HOLDER_____

POLICY HOLDER'S DATE OF BIRTH_____SS#_____

I UNDERSTAND THAT CERTAIN CHARGES MAY NOT BE COVERED BY MY INSURANCE AND I AM FINANCIALLY RESPOSIBLE FOR ALL CHARGES INCURRED.

_____DATE_____

I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE PAYMENT OF BENEFITS TO THE PHYSICIAN OR SUPPLIER FOR SERVICES RENDERED.

_____DATE_____