

PLEASE COMPLETE FORM

Patients Name _____
Address _____
Patient Employed By _____
Address _____ Phone# _____
Social Security# _____

Social Security Numbers (if patient minor)
Father _____ Mother _____
Date of Birth _____ Date of Birth _____

INSURANCE COVERAGE

Primary Coverage
Name of Subscriber _____

Secondary Coverage
Name of Subscriber _____

Medical Insurance Company _____

Medical Insurance Company _____

Address _____

Address _____

Name of Group _____
Policy# _____
Group# _____
Effective Date of Coverage _____

Name of Group _____
Policy# _____
Group# _____
Effective Date of Coverage _____

Dental Insurance _____

Dental Insurance _____

Address _____

Address _____

Name of Group _____
Policy# _____
Group# _____
Effective Date of Coverage _____

Name of Group _____
Policy# _____
Group# _____
Effective Date of Coverage _____

I have reviewed the following treatment plan. I authorize release of any information relating to this claim.

Signature of (patient or parent if minor) _____ Date _____

I hereby authorize payment of my group insurance benefits, otherwise payable to me, to the dentist listed below.

Signature (Insured person) _____ Date _____