

Insurance Information

Your Name: _____ Name of Insured (Insurance Holder): _____

What is your relationship to insured? Self Spouse Child Other

If you are 18 or older (on your parents plan), are you a full time student? Yes No
Name of School _____

Have you used your dental insurance within the last year? Yes No

Insurance Plan Name: _____ ** Group #: _____ ID#: _____

Address: _____ (____) _____ - _____
Street City State Zip Code Phone #

Please complete if this information has not been given to us as either "Patient" or "Responsible Party" Information.

Name of Insured _____ Birth Date: ____/____/____
Last First MI (Preferred Name) Sex: Male Female
Status: Married Single Child

Social Security # ____ - ____ - ____ Drivers License # _____ E-mail Address: _____

Address _____
Street Apartment # City State Zip Code

Mailing Address: _____
(if different than above) Street Apartment # City State Zip Code

Phone #'s: Home (____) ____ - ____ Cell (____) ____ - ____ Work (____) ____ - ____ ext ____

Fax (____) ____ - ____ Other (____) ____ - ____ Best times and phone # to call: _____

Employer's Name: _____ Occupation: _____

Address _____
Street Suite # City State Zip Code

** As a courtesy for our patients, we will take assignment of your "primary" insurance payments and ask that you pay only the portion we anticipate to not be covered. After your "primary" policy has paid, we will bill you for any remaining balance. If you have a "secondary" insurance policy, once your "primary" benefits have been received, we will provide any documentation that you may need to be reimbursed by that policy.