

INSURANCE INFORMATION

Subscriber (Policy Holder) Name: First:_____ Last:_____

Marital Status: Married___ Single___ Other___

Address: _____

SSN: _____ Birthdate: _____

Phone: (h):_____ (w):_____

Carrier Name: _____

Address: _____

Phone: _____

Group Number: _____

Type Dental___ Medical___

Employer Name: _____

Address: _____

Patient

Relationship To Employee: Self Spouse Child Other_____

If Full Time Student

School_____

Other Insurance (If Yes Complete The Following)

Carrier Name: _____

Address: _____

Phone: _____

Group Number: _____

Type Dental___ Medical___

Other Subscriber(Policy Holder)

Name: First:_____ Last:_____

Address: _____

SSN: _____ Birthdate: _____

Phone: (h):_____ (w):_____

Relationship To Patient Self Spouse Parent Other_____

Employer Name: _____

Address: _____

It is your responsibility to know who your insurance company is and your coverage. Treatment is not based on insurance coverage. We will not be responsible for any delays caused by incorrectly supplied information or insurance company delays. By completing this form you allow us to bill your insurance carrier. Thank you.