Dental Benefit Information

Primary Insurance:

Policy Holder's Name: _____ Patient's Name: _____

Relation to Patient _____ Soc. Sec #_____

Address (if different from patient) _____

Home Phone _____ Cell Phone _____

Insurance Company _____ Phone Number _____

Subscriber #_____ Group # _____

Employer (for insurance) _____ Business Address: _____

Secondary Insurance:

Is patient covered by additional insurance? **( )**Yes **( )**No Policy Holder's Name:_____

Relation to Patient _____ Soc. Sec # _____

Address (if direct from patient) _____

Home Phone _____ Cell Phone _____

Insurance Company _____ Phone Number _____

Subscriber #_____ Group # _____

Employer (for insurance) _____ Business Address: _____

I authorize the insurance company(ies) indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of the signature on all insurance submissions.

I authorize the dentist release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date: _____