

**Name of Patient:** \_\_\_\_\_

**PRIMARY INSURANCE**

Name of Insured: _____		Relationship to patient: _____	
_____	_____	_____	_____
Last Name	First Name	MI	
Insured Birthdate: ____ / ____ / _____		Insured Soc. Sec.# _____ - _____ - _____	Home Phone: (____) ____ - _____
Address (if different from patient): _____			
_____		_____	_____
Address		City	State Zip Code
Insured Employed by: _____		Occupation: _____	Bus. Phone: (____) ____ - _____
Business Address: _____			
_____		_____	_____
Address		City	State Zip Code
Insurance Company: _____		Phone: (____) ____ - _____	
Contract #: _____		Group #: _____	Subscriber #: _____

Is patient covered by additional insurance? \_\_\_\_ yes / \_\_\_\_ no

**SECONDARY INSURANCE**

Name of Insured: _____		Relationship to patient: _____	
_____	_____	_____	_____
Last Name	First Name	MI	
Insured Birthdate: ____ / ____ / _____		Insured Soc. Sec.# _____ - _____ - _____	Home Phone: (____) ____ - _____
Address (if different from patient): _____			
_____		_____	_____
Address		City	State Zip Code
Insured Employed by: _____		Occupation: _____	Bus. Phone: (____) ____ - _____
Business Address: _____			
_____		_____	_____
Address		City	State Zip Code
Insurance Company: _____		Phone: (____) ____ - _____	
Contract #: _____		Group #: _____	Subscriber #: _____

Is the patient covered by a third or more additional insurances? \_\_\_\_ yes / \_\_\_\_ no

I authorize release of any information relating to evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

**I understand that any treatment plans estimating insurance benefits are estimates only and may be different from the actual plan payment. I also understand that I am responsible for any charges not covered by my insurance(s).**

\_\_\_\_\_  
Signature

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_