Confidential Patient Information-Insurance

DENTAL INSURANCE INFORMATION

Primary Ins.: _____ Employee SSN: _____

Insurance Co. Address: _____ DOB ___/___/___

Insured Employee: _____ Relationship to Patient: _____

Employer: _____ Policy #: _____

Secondary Ins.: _____ Employee SSN: _____

Insurance Co. Address: _____ DOB ___/___/___

Insured Employee: _____ Relationship to Patient: _____

Employer: _____ Policy #: _____

PERSON RESPONSIBLE FOR THE ACCOUNT

Name: _____ SSN: _____ Drivers License: _____

Address: _____ City: _____ State: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

I understand that payment is my obligation regardless of insurance or any other third party involvement.

SIGNATURE: _____ **DATE:** _____