PATIENT INSURANCE INFORMATION

DENTAL INSURANCE COMPANY NAME:_____

IS THE POLICY HOLDER THE….PATIENT….PARENT…..SPOUSE…..OTHER_____

POLICY HOLDER NAME_____

POLICY HOLDER ADDRESS:_____

POLICY HOLDER PHONE:_____

POLICY HOLDER SOCIAL SECURITY;#_____

POLICY HOLDER DATE OF BIRTH:_____

IS THIS AN INSURANCE PLAN THROUGH AN EMPLOYER?_____

NAME OF EMPLOYER:_____

GROUP NUMBER:_____

INSURANCE ADDRESS:_____

INSURANCE PHONE:_____

MEDICAL INSURANCE COMPANY NAME:_____

IS THE POLICY HOLDER THE….PATIENT…..PARENT…..SPOUSE….OTHER_____

POLICY HOLDER NAME:_____

POLICY HOLDER ADDRESS:_____

POLICY HOLDER PHONE:_____

POLICY HOLDERS SOCIAL SECURITY #:_____

POLICY HOLDER DATE OF BIRTH:_____

IS THIS AN INSURANCE PLAN WITH AN EMPLOYER?_____

NAME OF EMPLOYER:_____

GROUP NUMBER:_____

INSURANCE ADDRESS:_____

INSURANCE PHONE#:_____

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to the Regional Oral Surgery Center of the insurance benefits otherwise payable to me.

SIGNED X_____DATE_____