

GUARANTOR AND INSURANCE SUBSCRIBER INFORMATION

Person Responsible for Account: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone# \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_



DENTAL INSURANCE INFORMATION (SUBSCRIBER)

Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_\_

Address (if different from Patient's) \_\_\_\_\_

SS# or Insured ID# \_\_\_\_\_ Employee ID# \_\_\_\_\_ Group # \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Are you covered by an additional Dental Insurance? \_\_\_\_\_ Yes \_\_\_\_\_ No



PATIENTS

| NAME  | RELATION TO INSURED | DATE OF BIRTH |
|-------|---------------------|---------------|
| _____ | _____               | _____         |
| _____ | _____               | _____         |
| _____ | _____               | _____         |

I authorize my insurance company to pay to the dentist all insurance benefits, otherwise payable to me, for services rendered on myself or any family member covered under this plan. I authorize the use of this signature on all insurance submissions and authorize the release of all information necessary to secure payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by my insurance.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

