INSURANCE INFORMATION

PATIENT INFORMATION:

Patient: _____ **M** / F DOB: ___/___/___ Age: _____

SS#:_____ Single Married Separated Divorced Widowed Dependent

Occupation: _____ Employer:_____

PRIMARY INSURANCE INFORMATION:

Are you covered by dental insurance? **Y N**

Insurance Company: _____ Phone: _____

Address:_____

City:_____ State: _____ Zip Code:_____

Name of Policy Holder: _____Policy Holder DOB: ____/_____/____

ID# or SS# of Policy Holder: _____Group #:_____

Policy Holder employed by:_____

Relationship to patient: Self Spouse Child Other

SECONDARY INSURANCE INFORMATION:

Are you covered by a secondary dental insurance? **Y N**

Insurance Company: _____ Phone:_____

Address:_____

City: _____ State: _____ Zip Code: _____

Name of Policy Holder: _____ Policy Holder DOB: ____/____/____

ID# or SS# of Policy Holder: _____ Group #: _____

Policy Holder employed by: _____

Relationship to patient: Self Spouse Child Other

If you have insurance, please read and authorize the following:

I authorize release of any information relating to dental claims and understand that I am responsible for all costs of dental treatment. I authorize payment of the group insurance benefits otherwise payable to me directly to Monument Family Dentistry.

Signature of Patient or Guardian_____ **Date:**_____