

INSURANCE INFORMATION

Please complete the information below and present insurance cards to the receptionist.

DENTAL INSURANCE

Insured Party: _____ Date of Birth: _____

Relationship to Patient: _____ SS#: _____

Employer: _____

Insurance Company Name: _____

Claims Address: _____

Policy #: _____ Group #: _____

MEDICAL INSURANCE

Insured Party: _____ Date of Birth: _____

Relationship to Patient: _____ SS#: _____

Employer: _____

Insurance Company: _____

Claims Address: _____

Policy #: _____ Group #: _____

INSURANCE AUTHORIZATION ASSIGNMENT

I hereby authorize all/any doctors associated with the Oral & Maxillofacial Surgery to furnish information to insurance carriers concerning illness/accident or any treatments. I hereby assign to the physician(s) all payments for dental/medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Date: _____ Signature of Responsible Party: **X** _____