PATIENT INSURANCE INFORMATION

PATIENT INFORMATION

Last Name: ---------------------------------- First Name: ------------------------ Middle Initial: --------

Date of Birth: -------------------------------- Nickname: ---------------------------Sex: ☐Male ☐Female

Street: -- ------------- City------------------------ State------- Zip: -----------

Home Phone------------------------------- Cell----------------------------- E-mail: -------------------------------

PRIMARY INSURANCE HOLDER

Title: Mr. Mrs. Ms. Dr.

Last Name--------------------------------- First Name-------------------------------- Middle Initial: --------------

Social Security Number------------------------------- Sex: ☐Male ☐Female

Date of Birth: --- Age: -------------------- Relation to Patient------------

Street: --- City: ------------------------- State: --------- Zip--------

Employer: -- Business Telephone: -----------------------------------

Insurance Company-----------------------------------Address: --

Subscriber ID: -- Group Number: ---

SECONDARY INSURANCE HOLDER

Title: Mr. Mrs. Ms. Dr.

Last Name---------------------------------- First Name--------------------------------- Middle Initial: --------------

Social Security Number-------------------------------- Sex: Male Female

Date of Birth: --- Age: --------------------- Relation to Patient------------

Street: --- City: -------------------------- State: --------- Zip--------

Employer: -- Business Telephone: -------------------------------------

Insurance Company-------------------------------------Address: --

Subscriber ID: -- Group Number: ---

☐ I do not have insurance.

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby authorize payment directly to Howell Pediatric Dentistry for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or dependents.

I authorize the above doctor or any provider of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party-- Date: --------------------