

INSURANCE INFORMATION

Please provide us with your insurance card(s) if available

PATIENT NAME: _____ **DATE OF BIRTH:** _____

PRIMARY INSURANCE:

Insured's Name: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ Social Security of ID #: _____

Insured's Address and Phone #: _____

* _____

Insurance Company Name and Address: _____

* _____

Insurance Co. Phone #: _____ Group #: _____

Employer's Name/Work Phone #: _____

Do you have dual coverage: _____ If yes, please complete the following:

SECONDARY INSURANCE:

Insured's Name: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ Social Security of ID #: _____

Insured's Address and Phone #: _____

* _____

Insurance Company Name and Address: _____

* _____

Insurance Co. Phone #: _____ Group #: _____

Employer's Name/Phone #: _____

I hereby authorize payment directly to Frank J. Stich, III, DDS, MSD of the insurance benefits otherwise payable to me.

Insured's/Responsible Party Signature

Date

Please remember to inform us if your insurance company changes!