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DENTAL EXTRACTIONS * JAW SURGERIES * DENTAL IMPLANTS

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

Patient's Name: ______________________________________ Date : ____

Patient's Address:___________________________________ City: ___________________ State: ________ Zip:____________

Home Phone:______________________________ Work Phone: __________________ Cell Phone: ___________________

Patient's date of Birth: ______________________________ SSN# ____

Is the patient a full-time student? ☐ Yes ☐ No If yes, where?____

INSURANCE INFORMATION: **PRIMARY INSURANCE**

Name of Subscriber:____

Date of Birth:__________________ SSN# ____________________ _ DL# ____

Subscriber's Address ________________________________ City: ___________________ State: ________ Zip:___________

Home Phone: ______________________________ Work Phone: __________________ Cell Phone: _____________________

Employer: ____

Employer's Address ________________________________ City: ___________________ State: ________ Zip:____________

Name of Dental Insurance Company ____

Address ____ City: ___________________ State: ________ Zip:____________

Group #___________ ________________________________: ___________________ Phone:__________________________

Relationship to patient: ☐ Spouse ☐ Child ☐ Parent Other: ____

(Please specify if not blood related, e.g. step, half, divorced)

Is the patient covered by a second insurance company? ☐ Yes ☐ No

SECONDARY INSURANCE

Name of Subscriber:____

Date of Birth:__________________ SSN# ____________________ _ DL# ____

Subscriber's Address ________________________________ City: ___________________ State: ________ Zip:___________

Home Phone: ______________________________ Work Phone: __________________ Cell Phone: _____________________

Employer: ____

Employer's Address ________________________________ City: ___________________ State: ________ Zip:____________

Name of Dental Insurance Company ____

Address ____ City: ___________________ State: ________ Zip:____________

Group #___________ ________________________________: ___________________ Phone:__________________________

Relationship to patient: ☐ Spouse ☐ Child ☐ Parent Other: ____

(Please specify if not blood related, e.g. step, half, divorced)

____

Signature