

# BILLING INFORMATION AND INSURANCE COVERAGE

DATE \_\_\_\_\_

## BILLING INFORMATION

PERSON RESPONSIBLE \_\_\_\_\_  
LAST NAME FIRST NAME INITIAL

ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP HOW LONG AT THIS ADDRESS

TELEPHONE NUMBERS ( \_\_\_\_\_ )  
INCLUDE AREA CODES HOME WORK EXT. CELL

EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_

OCCUPATION \_\_\_\_\_ HOW LONG \_\_\_\_\_

SPOUSE \_\_\_\_\_  
LAST FIRST INITIAL

SPOUSE'S EMPLOYER \_\_\_\_\_  
ADDRESS PHONE

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## INSURANCE COVERAGE

PRIMARY:  
EMPLOYEE: \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

EMPLOYER \_\_\_\_\_ INSURANCE CO. \_\_\_\_\_

INSURANCE CO. \_\_\_\_\_ DENTAL INSURANCE (NOT MEDICAL) PHONE # \_\_\_\_\_

ADDRESS \_\_\_\_\_ GROUP# \_\_\_\_\_ AREA CODE \_\_\_\_\_

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## ADDITIONAL INSURANCE: (SECONDARY)

EMPLOYEE: \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

EMPLOYER \_\_\_\_\_ INSURANCE CO. \_\_\_\_\_

INSURANCE CO. \_\_\_\_\_ DENTAL INSURANCE (NOT MEDICAL) PHONE # \_\_\_\_\_

ADDRESS: \_\_\_\_\_ GROUP # \_\_\_\_\_ AREA CODE \_\_\_\_\_

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**AUTHORIZATION:** I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_