INSURANCE INFORMATION

PATIENT INSURANCE INFORMATION DENTAL

PATIENT NAME (if dependent) | RELATION TO EMPLOYEE ( ) SELF ( ) SPOUSE ( ) CHILD ( ) OTHER

EMPLOYEE NAME

SS#/SIN OF EMPLOYEE | BIRTH DATE

EMPLOYER | UNION NO.

GROUP PLAN NAME | GROUP NO.

PRIMARY CARRIER NAME | POLICY NO.

SECONDARY CARRIER NAME | POLICY NO.

ITEM 3550 COLWELL 1.800.637.1140

PATIENT INSURANCE INFORMATION MEDICAL

PATIENT NAME (if dependent) | RELATION TO EMPLOYEE ( ) SELF ( ) SPOUSE ( ) CHILD ( ) OTHER

EMPLOYEE NAME

SS#/SIN OF EMPLOYEE | BIRTH DATE

EMPLOYER | UNION NO.

GROUP PLAN NAME | GROUP NO.

PRIMARY CARRIER NAME | POLICY NO.

SECONDARY CARRIER NAME | POLICY NO.

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AUTHORIZATION

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with all claims.

Patient or Parent/Guardian Signature Date Print Name