INSURANCE INFORMATION

Please complete the information below and present insurance cards to the receptionist.

DENTAL INSURANCE

Insured Party:_____ Date of Birth:_____

Relationship to Patient:_____ SS#:_____

Employer:_____

Insurance Company Name:_____

Claims Address:_____

Policy #:_____ Group #:_____

MEDICAL INSURANCE

Insured Party:_____ Date of Birth:_____

Relationship to Patient:_____ SS#:_____

Employer:_____

Insurance Company:_____

Claims Address:_____

Policy #:_____ Group #:_____

INSURANCE AUTHORIZATION ASSIGNMENT

I hereby authorize all/any doctors associated with the Oral & Maxillofacial Surgery to furnish information to insurance carriers concerning illness/accident or any treatments. I hereby assign to the physician(s) all payments for dental/medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Date:_____ Signature of Responsible Party: **X** _____