DENTAL INSURANCE INFORMATION

Patient Name: ____ Patient DOB: ____/____/______

Primary Dental Insurance Company Name: ____

Insurance ID#: _______________________ Group#: ________________ Provider Phone#: ___________

Insurance Claims Address: ____

Policy Holder Name: ___________________________________ Relationship to Patient: _____________

Policy Holder DOB: ____/____/______ Policy Holder Social Security# ____________________

Employer Name: ____

Secondary Dental Insurance Company Name: ____

Insurance ID#: _______________________ Group#: ________________ Provider Phone#: ___________

Insurance Claims Address: ____

Policy Holder Name: ___________________________________ Relationship to Patient: _____________

Policy Holder DOB: ____/____/______ Policy Holder Social Security# ____________________

Employer Name: ____

RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS

I authorize the release of any dental information necessary to process this claim & authorize the release of dental benefits to NOVA Pediatric Dentistry & Orthodontics for professional services rendered.

Signature: ____ Date: ____/____/______

Office Use Only: Participating or Non-Participating

updated 3/22