

**DENTAL INSURANCE INFORMATION**

Patient's Name: \_\_\_\_\_

**PRIMARY INSURANCE**

Subscriber's Name: \_\_\_\_\_

Subscriber's SS#: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_

Insurance Alternate I.D. Number (if applicable): \_\_\_\_\_

Employer's Name: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group Number: \_\_\_\_\_

Claim Mailing Address: \_\_\_\_\_

**SECONDARY INSURANCE**

Subscriber's Name: \_\_\_\_\_

Subscriber's SS#: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_

Insurance Alternate I.D. Number (if applicable): \_\_\_\_\_

Employer's Name: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group Number: \_\_\_\_\_

Claim Mailing Address: \_\_\_\_\_

I have completed the above questions to the best of my ability. If the information is incomplete, I do realize I will pay for my dental visits and submit for reimbursement from my insurance myself. I assume responsibility for fees associated with procedures performed regardless of dental coverage in effect. As a courtesy, Bresler-Richmond Dental Associates will submit charges to my insurance company on my behalf; however, if no payment is received within 60 days, the balance becomes my responsibility. I understand all copays and deductibles are due on the day the service is rendered. I certify that the insurance(s) listed here represent all coverage(s) in place as of today.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR GUARDIAN IF A MINOR

\_\_\_\_\_  
DATE