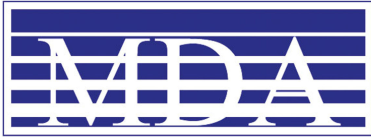

INSURANCE CARRIER INFORMATION

PATIENT NAME ______________________________________ DATE OF BIRTH _______________

RELATIONSHIP TO EMPLOYEE _________________________

EMPLOYEE NAME ____________________________________ DATE OF BIRTH _______________

EMPLOYEE SOCIAL SECURITY NUMBER ________________________________

EMPLOYEE'S MAILING ADDRESS ____

EMPLOYER ____

EMPLOYEERS MAILING ADDRESS ____

NAME OF INSURANCE COMPANY ____

MAILING ADDRESS ____

INSURANCE TELEPHONE NUMBER ____

GROUP NUMBER ____________________________________

DO YOU HAVE OTHER DENTAL COVERAGE? Yes ____ No ____ If yes, CONTINUE

EMPLOYEE NAME ____________________________________ DATE OF BIRTH _______________

EMPLOYEE SOCIAL SECURITY NUMBER ________________________________

EMPLOYEE'S MAILING ADDRESS ____

EMPLOYER ____

EMPLOYEERS MAILING ADDRESS ____

NAME OF INSURANCE COMPANY ____

MAILING ADDRESS ____

INSURANCE TELEPHONE NUMBER ____

GROUP NUMBER ___________________________________

I AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING TO DENTAL PROCEDURES PROVIDED FOR THE PATIENT TO THE INSUARNCE CARRIERS OR THEIR AUTHOIZED REPRESENTATIVES.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP BENEFITS OTHERWISE PAYABLE TO ME. IF MY CURRENT POLICY PROHIBITS DIRECT PAYMENT TO THE DOCTOR, I HEREBY INSTRUCT AND DIRECT THE INSURANCE COMPANY TO MAKE OUT THE CHECK TO ME AND MAIL IT AS FOLLOWS: C/O MORRISON DENTAL ASSOCIATES, P.C., P.O. BOX 13038, SAVNNAH, GA 31416.

SIGN ____ DATE _________________