



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 _____