Crofton

Dental Suite

PATIENT INSURANCE FORM/UPDATE

PATIENT NAME: _____

ADDRESS: _____

_____

SOCIAL SECURITY NUMBER: _____ **DATE OF BIRTH:** _____

PRIMARY INSURANCE

INSURED NAME: _____ **INSURED'S DATE OF BIRTH:** _____

RELATIONSHIP TO INSURED: _____ **SOCIAL SECURITY NUMBER:** _____

INSURED'S EMPLOYER: _____

INSURANCE COMPANY: _____

INS. ID#: _____ **GROUP #** _____

SECONDARY INSURANCE

INSURED'S NAME: _____ **INSURED'S DATE OF BIRTH:** _____

RELATIONSHIP TO INSURED: _____ **SOCIAL SECURITY NUMBER:** _____

INSURED'S EMPLOYER: _____

INSURANCE COMPANY: _____

INS. ID#: _____ **GROUP #:** _____

I UNDERSTAND THAT IF THE ABOVE INFORMATION IS INCORRECT, I WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED AT CROFTON DENTAL. I WILL ALSO BE RESPONSIBLE FOR SUBMITTING TO MY INSURANCE CARRIER FOR REIMBURSEMENT.

_____ _____

SIGNATURE – INSURED/RESPONSIBLE PARTY **DATE**