

Insurance Information Sheet
(Please complete all lines)

2011

PATIENT'S NAME:(Please Print) _____

PRIMARY **MEDICAL** INSURANCE: _____ PHONE #: _____

MEDICAL INSURANCE ADDRESS: _____

ID #: _____ GROUP#: _____

NAME of POLICY HOLDER: _____ RELATION TO PATIENT: _____

POLICY HOLDER'S BIRTH DATE: _____ POLICY HOLDER'S SS# : _____

POLICY HOLDER'S EMPLOYER: _____

SECONDARY **MEDICAL** INSURANCE: _____ PHONE #: _____

MEDICAL INSURANCE ADDRESS: _____

ID #: _____ GROUP#: _____

NAME of POLICY HOLDER: _____ RELATION TO PATIENT: _____

POLICY HOLDER'S BIRTH DATE: _____ POLICY HOLDER'S SS#: _____

POLICY HOLDER'S EMPLOYER: _____

PRIMARY **DENTAL** INSURANCE: _____ PHONE #: _____

DENTAL INSURANCE ADDRESS: _____

ID #: _____ GROUP# : _____

NAME of POLICY HOLDER: _____ RELATION TO PATIENT: _____

POLICY HOLDER'S BIRTH DATE: _____ POLICY HOLDER'S SS#: _____

POLICY HOLDER'S EMPLOYER: _____

SECONDARY **DENTAL** INSURANCE: _____ PHONE #: _____

DENTAL INSURANCE ADDRESS: _____

ID #: _____ GROUP#: _____

NAME of POLICY HOLDER: _____ RELATION TO PATIENT: _____

POLICY HOLDER'S BIRTH DATE: _____ POLICY HOLDER'S SS#: _____

POLICY HOLDER'S EMPLOYER: _____

I acknowledge I am financially responsible for any charges for services that are rendered to me by Oral Facial Surgery Institute. Any and all fees (attorney, collection agency, etc.) will be the responsibility of the patient or guarantor.

PATIENT'S (or Guardian's) SIGNATURE _____ DATE _____