# INSURANCE INFORMATION

**Primary Insurance Information:**

Policy Holder: ______________________________ Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Holder Address, City, State, Zip: ______________________________________________________________________

Policy Holder ID#: _____________________________________ Policy Holder Birth Date: _____________________

**Patient's SS#: _____________________________________ Patient's Birth Date: __________________________________**

Policy Holder Employer: ____________________________ Employer Address: _____________________________________

Employer City, State, Zip: __________________________________________ Work Phone: ________________________

Dental Insurance Company: ________________________________________________________

**Secondary Insurance Information:**

Policy Holder: ______________________________ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Holder Address, City, State, Zip: ______________________________________________________________________

Policy Holder ID#: _____________________________________ Policy Holder Birth Date: _____________________

**Patient's SS#: _____________________________________ Patient's Birth Date: __________________________________**

Policy Holder Employer: ____________________________ Employer Address: _____________________________________

Employer City, State, Zip: __________________________________________ Employer Phone: ________________________

Dental Insurance Company: ________________________________________________________

☐ PLEASE CHECK HERE IF YOU HAVE **MORE THAN TWO** DENTAL INSURANCE CARRIERS

**Assignment & Release:**

Dr. Larry G. Smith may retain all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_______________________________________________________________ __________________________________

**Signature of Patient, Parent, Guardian, or Personal Representative** **Date Signed**