PATIENT DENTAL INSURANCE INFORMATION

405 S. MARKET ST. – P. O. BOX 278
BENSON, N. C. 27504
TELEPHONE (919) 894-4195

PATIENT NAME _____

PATIENT RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER_____
DATE OF BIRTH_____

PRIMARY INSURED INFORMATION

_____
EMPLOYER NAME

INSURED NAME_____**DATE OF BIRTH** _____
(FIRST – MIDDLE- LAST)

HOME ADDRESS

_____
(CITY – STATE – ZIP CODE)

PHONE: (HOME)_____ (CELL)_____

ID NUMBER: _____

GROUP NUMBER: _____

SECONDARY INSURED INFORMATION *(if applicable)*

_____
EMPLOYER NAME

INSURED NAME_____**DATE OF BIRTH** _____
(FIRST – MIDDLE- LAST)

HOME ADDRESS

_____
(CITY – STATE – ZIP CODE)

PHONE: (HOME)_____ (CELL)_____

ID NUMBER: _____

GROUP NUMBER: _____

RELEASE AND ASSIGNMENT

I AUTHORIZE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM AND ASSIGN AND REQUEST PAYMENT DIRECTLY TO MY DENTIST.

SIGNATURE_____ **DATE** _____