

PLEASE PROVIDE US WITH THE FOLLOWING DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE

SECONDARY

Employee Name _____

Employee Name _____

Birth Date _____

Birth Date _____

Social Security # _____

Social Security # _____

Employer _____

Employer _____

Work phone _____ Ext _____

Work phone _____ Ext _____

Dental Ins. Co. _____

Dental Ins. Co. _____

Address _____

Address _____

Phone () _____

Phone () _____

Group # _____

Group # _____

I hereby authorize my insurance benefits to be paid directly to San Jose Endodontics. I am financially responsible for services not covered or paid for by my insurance company for any reason. I also authorize this office to release any information required about my dental condition/treatment needed to determine benefits for as long as it takes to have the claim settled.

Signature _____ Date _____

(Patient, Parent or Guardian)