INSURANCE QUESTIONARE

Patients Name_______________________________ ____________DOB_____________________________

Patient's Mailing Address____

NAME OF INS. COMPANY____

INS. CLAIMS ADDRESS____

INSURANCE GROUP # ________________________________INSURED'S ID#___________________________

INS. CLAIMS PHONE ____

INSURED'S NAME _________________________ ______________DOB_________________________________

INSURED'S PHONE #__________________________SS# ____

RELATION TO PATIENT ____

INSURED'S MAILING ADDRES____

NAME OF EMPLOYER ____

ADDRESS OF EMPLOYER ____

EMPLOYER PHONE # ____

SECONDARY INSURANCE

NAME OF INS. COMPANY____

INS. CLAIMS ADDRESS____

INS. CLAIMS PHONE #____

INS. GROUP #_______________________________________INSURED"S ID #___________________________

INSURED'S NAME________________________ ________SS#____

INSURED'SPHONE#__________________________ _____________DOB______________________________

RELATION TO PATIENT ____

MAILING ADDRESS ____

INSURANCE GROUP # ____

NAME OF EMPLOYER ____

ADDRESS OF EMPLOYER_____________________ ________________PHONE #___________________________

PLEASE INITIAL:

_____I AUTHORIZE THE RELEASE OF ALL INFORMATION RELATING TO PATIENT DENTALTX.

_____I AUTHORIZE PAYMENT DIRECTLY TO DR. RUBIN.

_____IF FOR ANY REASON, THE INSURANCE COVERAGE IS TERMINATED, I WILL TAKE FULL

RESPONSIBILITY FOR ALL BALANCES FOR THE REMAINDER OF TREATMENT.