

PATIENT BILLING INFORMATION

DATE: _____ DATE OF BIRTH: _____ Gender: _____ Marital Status: _____

PATIENT NAME: _____

Mailing Address: _____ City/State: _____ Zip: _____

Billing Address (if different than mailing address): _____

_____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail Address: _____ Pager Number: _____

Employer: _____ Full Time / Part Time Student, if yes, Where: _____

Social Security Number: _____ Referred By: _____

If you have dental insurance through your own employment, please complete the 1st section below. If you are covered through your spouse, please complete the 2nd section with his/her information. If you are a minor dependent, please complete the 1st section with that parent's information. If you are covered under another parent, please complete the 2nd section with that parent's information. If you have a 3rd insurer (tertiary coverage), please use the 3rd section below.

Section 1 – Primary Insurance

Subscriber's Name: _____ Date of Birth: _____

Employer: _____ Business Phone: _____

Social Security Number: _____ Home Phone: _____

Dental Insurance Company: _____ Group Number: _____

Claim Mailing Information: _____

Insurance Company Telephone Number: _____

Section 2 – Secondary Insurance

Subscriber's Name: _____ Date of Birth: _____

Employer: _____ Business Phone: _____

Social Security Number: _____ Home Phone: _____

Dental Insurance Company: _____ Group Number: _____

Claim Mailing Information: _____

Insurance Company Telephone Number: _____

Section 3 – Tertiary (3rd Party Insured)

Subscriber's Name: _____ Date of Birth: _____

Employer: _____ Business Phone: _____

Social Security Number: _____ Home Phone: _____

Dental Insurance Company: _____ Group Number: _____

Claim Mailing Information: _____

Insurance Company Telephone Number: _____