



**Jorge Oaxaca DDS, Inc. and Howard Ong DDS, FAGD, Inc.**

*Restorative, Cosmetic and Implant Dentistry*

**Insurance Info:**

*Primary Dental Insurance*

See copy of ins. card(s) attached

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

CITY

STATE

ZIP

Phone #: (\_\_\_\_) \_\_\_\_\_

Insured's SSN/ID #: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's Employer: \_\_\_\_\_

*Secondary Dental Insurance*

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

CITY

STATE

ZIP

Phone #: (\_\_\_\_) \_\_\_\_\_

Insured's SSN/ID #: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's Employer: \_\_\_\_\_

**Insurance Assignment and Release**

I certify that I am currently covered by insurance with \_\_\_\_\_ and assign directly to Jorge Oaxaca DDS, Inc. and Howard Ong DDS, FAGD, Inc., all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions.

Jorge Oaxaca DDS, Inc. and Howard Ong DDS, FAGD, Inc. 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 payable for related services. This consent to remain in effect until cancelled in writing.

**I have read and understand the above terms and conditions.**

\_\_\_\_\_  
Signature of Patient or Parent/Guardian

\_\_\_\_\_  
Date