INSURANCE INFORMATION

Do you have dental insurance? No Yes
Do you have medical insurance? No Yes
Full-time Student? No Yes _____
School City State

PRIMARY DENTAL

Subscriber_____

I.D./S.S. #_____

Date of Birth_____

Employer_____

Insurance Co._____

Policy/Group#_____

SECONDARY DENTAL

Subscriber_____

I.D./S.S.#_____

Date of Birth_____

Employer_____

Insurance Co._____

Policy/Group#_____

PRIMARY MEDICAL

Subscriber_____

I.D./S.S#_____

Date of Birth_____

Employer_____

Insurance Co._____

Policy/Group#_____

SECONDARY MEDICAL

Subscriber_____

I.D./S.S.#_____

Date of Birth_____

Employer_____

Insurance Co._____

Policy/Group_____

Assignment and Release: I hearby authorized my insurance benefits to be paid directly to Dr.'s Shuken, Foltz and I understand I am financially responsible for non-covered services. I also authorize the doctor to release my information required.

Signature or Parent Signature if Patient is a Minor Date