

DENTAL INSURANCE INFORMATION

Patient's Name: _____ Date of Birth: _____

PRIMARY DENTAL PLAN

Name of Subscriber: _____

Birth Date: _____ Social Security # _____

Address: _____
Street City State Zip Code

Is the Subscriber a patient here? YES NO

Employer Name: _____ City, State: _____

Dental Plan Name: _____

Subscriber ID # _____ Group # _____

Relationship to Patient Self Spouse Child Other _____

SECONDARY DENTAL PLAN

Name of Subscriber: _____

Birth Date: _____ Social Security # _____

Address: _____
Street City State Zip Code

Is the Subscriber a patient here? YES NO

Employer Name: _____ City, State: _____

Dental Plan Name: _____

Subscriber ID # _____ Group # _____

Relationship to Patient Self Spouse Child Other _____

I hereby authorize Dr Hirschfeld to release all information necessary to my insurance carrier(s) to secure payment of benefits. I hereby authorize my insurance carrier(s) to assign directly to Dr Hirschfeld all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signature of Patient/Guardian: _____ Date: _____

Printed Name: _____

Signature of Primary Insured: _____ Date: _____

Printed Name: _____

Signature of Secondary Insured: _____ Date: _____

Printed Name: _____