INSURANCE INFORMATION

Patient's Name: ________________________________ Date of Birth: ________________

Social Security Number: _________________ Employer: __________________________

PRIMARY **DENTAL** INSURANCE PLAN

Subscriber: _________________________________ Date of Birth: ___________________

Address: _______________________________________ Relation to Patient: ___________

Insurance Company: _______________________ Phone Number: ____________________

Address: ____

Employer (Group Name): ____

Employer Address: ____

Group Number: ___________________________ Subscriber ID #: ___________________

SECONDARY **DENTAL** INSURANCE PLAN

Subscriber: ___________________________________ Date of Birth: ________________

Address: ______________________________________ Relation to Patient: ____________

Insurance Company: ______________________Phone Number: ______________________

Address: ____

Employer (Group Name): ____

Address: ____

Group Number: ________________Subscriber ID Number: _________________________

I, hereby authorize Eugene W. Lawnicki, D.M.D. to release information related to my insurance claims. I further authorize payment directly to Eugene W. Lawnicki, D.M.D. of benefits due me for treatment as described in my insurance claims. I understand that I am financially responsible for all charges not covered by my insurance and that all outstanding balances over 30 days are subject to a 1 ½% monthly interest charge. I give permission to Dr. Lawnicki and his clinical staff to take any necessary diagnostic films, photos, or study models to properly enable complete diagnosis and treatment.

Signed: ____ Dated: ________________________________