NAPERVILLE PERIODONTICS JOHN P. McNAMARA DDS, MS

INSURANCE AND BILLING INFORMATION

THE FOLLOWING INFORMATION IS CONFIDENTIAL AND FOR OUR RECORDS ONLY AND WILL BE USED ONLY FOR THE PURPOSE OF BILLING AND FILING INSURNACE ON YOUR BEHALF

Patient's name_____
Date of Birth_____
Check appropriate box [ ] minor [ ] single [ ] married [ ] divorced
Social Security Number_____
Patient's employer _____
Person responsible for payment of this account_____
Name of dental insurance company_____
Group Number_____

Complete the information below only if the patient is not the insured party.

Name of insured_____
Insured's date of birth_____
Insured's employer_____
Insured's social security number _____
Insured's relation to patient _____

Complete the information below only if the patient is covered by a second dental insurance policy.

Name of insured_____
Insured's date of birth_____
Insured's employer_____
Insured's social security number_____
Insured's relation to patient_____
Name of insured's dental insurance company_____
Group number_____