

INSURANCE INFORMATION

PATIENT'S NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

\*\*\*PRIMARY\*\*\*

\*\*\*SECONDARY\*\*\*

NAME OF INSURED:

NAME OF INSURED:

\_\_\_\_\_  
ADDRESS, CITY, STATE, ZIP:

\_\_\_\_\_  
ADDRESS, CITY, STATE, ZIP:

\_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_  
SS# \_\_\_\_\_

\_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_  
SS# \_\_\_\_\_

NAME OF INSURANCE CO:

NAME OF INSURANCE CO:

\_\_\_\_\_  
GROUP/ PLAN# \_\_\_\_\_  
INSURANCE CO. ADDRESS:

\_\_\_\_\_  
GROUP/ PLAN# \_\_\_\_\_  
INSURANCE CO. ADDRESS:

INSURANCE CO. PHONE:

INSURANCE CO. PHONE:

\_\_\_\_\_  
EMPLOYER NAME:

\_\_\_\_\_  
EMPLOYER NAME:

\_\_\_\_\_  
ADDRESS:

\_\_\_\_\_  
ADDRESS:

\_\_\_\_\_  
CITY, STATE, ZIP

\_\_\_\_\_  
CITY, STATE, ZIP

\*\*I hereby instruct and authorize that \_\_\_\_\_ Insurance Company is to pay by check (made payable to Dr. Mitchell Poiset) the professional or dental expense benefits allowable, and otherwise payable to me under my current insurance policy. THIS IS A DIRECT ASSIGNMENT OF MY BENEFITS UNDER THIS POLICY. A photocopy of this assignment shall be considered as effective and valid as the original. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_