Insurance Information

Name:_____

Do you have dental insurance? Yes:____ No:____

Name of employer:_____
Employer's Address:

_____
Street City State Zip

Insurance Company Name:_____

Insurance Phone: _____

Group #:_____ Insured ID#:_____

Plan Name:_____
Insurance Address:

_____
Street (Include PO Box) City State Zip

Insured Member Name (If different from your own):

_____
Last First Middle Mr./Mrs./Ms./Dr.

Insured Social Security:_____

Insured's Address:

_____
Street City State Zip

Insured's Date of Birth:___/___/___ Relationship to patient:_____

Authorization:

I affirm that the information I have given on this form is correct to the best of my knowledge, and it is my responsibility to inform this office of any changes in my medical status. I authorize my insurance benefits to be paid directly to Arnold K. Chernoff DDS, and I understand that I am responsible for payment of deductibles, co-payments, and any balances not covered by my insurance. I also authorize Arnold K. Chernoff DDS to release any information required to process my claims. I understand that payment is due at the time of service unless other financial agreements have been made.

_____

_____
Signature Date