Insurance Information Sheet **2011**

(Please complete all lines)

PATIENT'S NAME:*(Please Print)*____

PRIMARY MEDICAL INSURANCE:__________________________PHONE #:______________________________

MEDICAL INSURANCE ADDRESS: ____

ID #:____________________________________ GROUP#: ____

NAME of POLICY HOLDER:_______________________RELATION TO PATIENT:_________________________

POLICY HOLDER'S BIRTH DATE:______________________POLICY HOLDER'S SS# :_____________________

POLICY HOLDER'S EMPLOYER: ____

SECONDARY MEDICAL INSURANCE:_______________________________PHONE #: _____________________

MEDICAL INSURANCE ADDRESS:____

ID #:____________________________________ GROUP#:____

NAME of POLICY HOLDER:_______________________RELATION TO PATIENT:_________________________

POLICY HOLDER'S BIRTH DATE:_____________________POLICY HOLDER'S SS#: _______________________

POLICY HOLDER'S EMPLOYER:____

PRIMARY DENTAL INSURANCE:___________________________________PHONE #:______________________

DENTAL INSURANCE ADDRESS: ____

ID #:____________________________________ GROUP# : ____

NAME of POLICY HOLDER:___________________________RELATION TO PATIENT:______________________

POLICY HOLDER'S BIRTH DATE:____________________POLICY HOLDER'S SS#:________________________

POLICY HOLDER'S EMPLOYER: ____

SECONDARY DENTAL INSURANCE:______________________________PHONE #:________________________

DENTAL INSURANCE ADDRESS: ____

ID #:____ GROUP#: ____

NAME of POLICY HOLDER:___________________________RELATION TO PATIENT: ____________________

POLICY HOLDER'S BIRTH DATE:____________________POLICY HOLDER'S SS#:_________________________

POLICY HOLDER'S EMPLOYER:____

I acknowledge I am financially responsible for any charges for services that are rendered to me by Oral Facial Surgery Institute. Any and all fees (attorney, collection agency, etc.) will be the responsibility of the patient or guarantor.

PATIENT'S (or Guardian's) SIGNATURE___________________________________ DATE________________________