

**Insurance Information Sheet**  
*(Please complete all lines)*

**2010**

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: \_\_\_\_\_

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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 \_\_\_\_\_