INSURANCE INFORMATION FORM

PATIENT INFORMATION

Patient Name: _____
Birthdate: _____
Relationship to Subscriber: _____

SUBSCRIBER INFORMATION

Subscriber Name: _____
Birthdate: _____
Subscriber ID Number: _____
Subscriber Phone Number: _____

INSURANCE INFORMATION

Insurance Company: _____
Employer: _____
Policy Number: _____
Group Number: _____
Insurance Address: _____
Insurance Phone Number: _____

SECONDARY INSURANCE

Insurance Company: _____
Employer: _____
Policy Number: _____
Group Number: _____
Insurance Address: _____
Insurance Phone Number: _____

We will use the above information to verify your eligibility and benefits. As a courtesy, we will submit a pre-treatment estimate and monthly claims on your behalf, if requested. Please be advised that all payments are due at the time of service. You will have the option on the Insurance Claim Form to have payments sent directly to Heather Buccieri, DDS, MS. If you elect not to sign, the payments will be sent directly to you. Any payments received from your insurance company will be applied directly to your account. If your account is paid in full, a reimbursement check will be issued.

Signature: _____ Today's Date: _____