INSURANCE COMPANY INFORMATION

Person Responsible for Account _____
(Print) Parent if child under 18 years old

Address_____City_____State_____Zip_____

Employer_____Phone_____

Primary Dental Insurance

Primary insured person name: _____ Birth Date _____
SS#_____Occupation_____Employer_____
Insurance Company_____ Phone _____
Contract #_____Group #_____Subscriber # _____
Relationship to patient_____

Additional Dental Insurance

Primary insured person name: _____ Birth date_____
SS#_____Occupation_____Employer_____
Insurance Company_____ Phone _____
Contract #_____Group #_____Subscriber # _____
Relationship to patient_____

Medical Insurance Coverage (if your plan has basic dental coverage)

Primary insured person name: _____ Birth date_____
SS#_____Occupation_____Employer_____
Insurance Company_____ Phone _____
Contract #_____Group #_____Subscriber # _____
Relationship to patient_____

Authorization

I certify assignment of insurance benefit payments to Dr. Borham, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize Dr. Borham to submit health/dental care information to above named insurance company/companies and their agents for the purpose of obtaining payment for services and/or determining benefits for related services.

Printed Patient Signature _____
(Parent if child under 18)

Patient/Parent Signature_____ **Date** _____