DOVE FAMILY DENTISTRY

Billing and Insurance Information

DATE ________________

PATIENT INFORMATION

Patient Name ____________________________ Nickname __________________ Birthdate ____________

Billing Address __________________________________ City ________________ State ______ Zip ________

City ________________ State ______ Zip _________ E-mail ____

Home Phone ________________ Cell Phone _____________ Social Security Number ________________

Employer _____________________________________ Occupation __________________________________

PRIMARY INSURANCE

Subscriber's Employer _______________________________________ Work Phone # _________________

Insurance Company ____ Group # _______________________

Subscriber's Name ____ Insurance Phone # _____________

Address (if different than patient) ____

City _______________________ State _____ Zip ___________ Subscriber's Birthdate __________________

Subscriber's Social Security # _______________________ Insurance ID # ___________________________

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

SECONDARY INSURANCE

Subscriber's Employer _______________________________________ Work Phone # _________________

Insurance Company ____ Group # _______________________

Subscriber's Name ____ Insurance Phone # _____________

Address (if different than patient) ____

City _______________________ State _____ Zip ___________ Subscriber's Birthdate __________________

Subscriber's Social Security # _______________________ Insurance ID # ___________________________

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

NO INSURANCE / RESPONSIBLE PARTY IF OTHER THAN PATIENT

Name _________________________________ Address ____

Home Phone __________________________ Cell Phone ____

Relationship to the patient ____