



DOVE FAMILY DENTISTRY
Billing and Insurance Information

DATE _____

PATIENT INFORMATION

Patient Name _____ Nickname _____ Birthdate _____

Billing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-mail _____

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 _____