

Patient Insurance Information

We would be happy to help file your insurance for you. In order to do so, we need the following information completed.

Patient: _____

Date of Birth: _____

Relationship to insured _____

Employee or Subscriber: _____

Address _____

Date of Birth _____

SS# _____

Employer Name _____

Address of employer _____

Insurance Company _____

Address _____

Customer/Claims Telephone # _____

Group number _____

Individual identification # _____

Is patient covered by another dental plan *yes* _____ *no* _____

If so who? _____

If dental benefits are to be assigned please read and sign below.

I hereby authorize payment of the dental benefits otherwise payable to me directly to Taylor Dental Associates, Inc./EZBraces.

Insured signature

Date