Date:___________________________

Insurance Information Worksheet

Name of Patient: ____
Date of Birth of Patient:____
SSN of patient:____
Subscriber's Name (primary insurance):_____________________________________
Relationship to patient: ______________________Employer name:___________________
Date of birth of Subscriber:____
SSN of Subscriber:____
Name of Subscriber's Dental Insurance:____
Address of Subscriber's Dental Insurance:______________________________________
____
Telephone number of Subscriber's Insurance:____________________________________
Group/Plan number:____
Subscriber's Name (secondary insurance):____________________________________
Relationship to patient:____
Date of Birth of Subscriber:____
SSN of Subscriber:____
Name of Subscriber's Dental Insurance:_____ ___________________________________
Address of Subscriber's Dental Insurance:______________________________________
Telephone number of Subscriber's Dental Insurance:_______________________________
Group/Plan number:____

Medical Insurance Information: this information is needed if your appointment is for bony or partially bony impacted third molars, jaw fracture or oral biopsies.

Name of Subscriber (primary):____
Name of Primary Medical Insurance: ____
Address of Primary Medical Insurance: ____
_____________________________________Plan number: _________________________
Telephone number of Primary Medical Insurance: __________________________________
Name of Subscriber (Secondary): ____
Name of Secondary Medical Insurance:____
Address of Secondary Medical Insurance: _______________________________________
_____________________________________Plan number:__________________________
Telephone number of Secondary Medical Insurance: _______________________________

Assignment and Release: I certify that the above information is correct. I hereby authorize my insurance benefits to be paid directly to Monroe Oral Surgery Group, L.L.C. or Howell Dental Surgery Group, P.A. and I am financially responsible for non-covered services. I also authorize Monroe Oral Surgery Group, L.L.C. or Howell Dental Surgery Group. P.A. to release any information required.

Signature of Patient or Legal Guardian: ______________________________________