Dental and Medical Insurance Information

Today's Date: ____/___/_____

****Please bring your Dental and Medical Insurance cards with you on your visit****

Primary Dental Insurance

- Patient's Name(s) :_____
- Patient's Address:_____City:_____State:_____Zip:_____
- Name of person who carries the insurance: _____Date of Birth: ___/___/_____
- Marital Status: ***Single, Married, Divorced, Separated***
- Employee Address:_____City:_____State:_____Zip_____

If separated or divorced make certain you give the correct mailing address and phone number of the person who carries the insurance and with whom the patient resides.

- Employee Social Security Number:_____-____-_____
- Place of Employment:_____
- Insurance Group Number:_____
- Identification Number:_____ Effective Date: _____/____/_____
- Dental Insurance Company Name:_____
- Mailing Address of Insurance Company:_____
- Dental Insurance Company Phone Number: ( )_____-_____

Secondary Dental Insurance

- Patient's Name(s) :_____
- Patient's Address:_____City:_____State:_____Zip:_____
- Name of person who carries the insurance: _____Date of Birth: ___/___/_____
- Marital Status: ***Single, Married, Divorced, Separated***
- Employee Address:_____City:_____State:_____Zip_____

If separated or divorced make certain you give the correct mailing address and phone number of the person who carries the insurance and with whom the patient resides.

- Employee Social Security Number:_____-____-_____
- Place of Employment:_____
- Insurance Group Number:_____
- Identification Number:_____ Effective Date: _____/____/_____
- Dental Insurance Company Name:_____
- Mailing Address of Insurance Company:_____
- Dental Insurance Company Phone Number: ( )_____-_____

I have been informed of the treatment plan and associates fees. I agree to be responsible for all charges for dental services and materials not paid by my dental plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

Sign_____Date: ____/____/_____

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Hamilton Dental Associates. Sign: _____Date: ___/___/_____

Primary Medical Insurance

- Patient's Name(s) :_____
- Patient's Address:_____City:_____State:_____Zip:_____
- Name of person who carries the insurance: _____Date of Birth: ___/___/_____
- Marital Status: ***Single, Married, Divorced, Separated***
- Employee Address:_____City:_____State:_____Zip_____

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- Place of Employment:_____
- Insurance Group Number:_____
- Identification Number:_____ Effective Date: _____/____/_____
- Medical Insurance Company Name:_____
- Mailing Address of Insurance Company:_____
- Medical Insurance Company Phone Number: ( )_____-_____

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- Patient's Name(s) :_____
- Patient's Address:_____City:_____State:_____Zip:_____
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- Medical Insurance Company Phone Number: ( )_____-_____