



Klockner Road Office, 2929 Klockner Road, Hamilton Square, NJ 08690 (609) 586-6603

Merrill Lynch Campus, 1300 Merrill Lynch Drive 0301, Pennington, NJ 08534-4122 (609) 274-8484

Kuser Road Office, NJ Family Care, 2501 Kuser Road (2nd Floor), Hamilton Township, NJ 08691 (609) 689-1212

DENTAL AND MEDICAL INSURANCE INFORMATION

Today's Date: ____ / ____ / ____

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.*

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: ____ / ____ / ____

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

continued on next page...

Secondary Dental Insurance (continued)

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: () _____ - _____

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 _____

**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: ____/____/____

Medical Insurance Company Name: _____

Mailing Address of Insurance Company: _____

Medical Insurance Company Phone Number: () _____ - _____

Secondary 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 _____

**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: ____/____/____

Medical Insurance Company Name: _____

Mailing Address of Insurance Company: _____

Medical Insurance Company Phone Number: () _____ - _____