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