Adult & Child Orthodontists Mayhew & Scheffler | Smiles Pediatric Dentists Conn & Hardaway

DENTAL INSURANCE INFORMATION

In order to assist you in determining your dental insurance benefit, the following information is necessary:

Name of Patient: _____ Date of Birth: _____

Name of Insured: _____ Date of Birth: _____

Address: _____

Social Security #:_____ Telephone: _____

Employed by: _____

Address: _____

Insurance Company: _____ Policy/Group #:_____

Address of Insurance Company: _____

Insurance Company Telephone: _____

Is patient covered under another dental plan? If so, please complete the following information:

Name of Insured: _____ Date of Birth: _____

Address: _____

Social Security #:_____ Telephone: _____

Employed by: _____

Address: _____

Insurance Company: _____ Policy/Group #:_____

Address of Insurance Company: _____

Insurance Company Telephone: _____

I hereby authorize release of any information relating to this claim.

_____ Date _____
Signature

I hereby authorize payment of insurance benefits directly to the below named dentist.

_____ Date _____
Signature

Please notify our office of any changes in your insurance policy as soon as possible.