

## San Diego Dental Specialists Dental Insurance Information

<u>Patients</u>	<input type="radio"/> Pediatric Dentistry	<input type="radio"/> Orthodontics	<input type="radio"/> Both		
_____ First Name	_____ M.I.	_____ Last Name	_____ Date of Birth	<input type="radio"/> M	<input type="radio"/> F
_____ First Name	_____ M.I.	_____ Last Name	_____ Date of Birth	<input type="radio"/> M	<input type="radio"/> F
_____ First Name	_____ M.I.	_____ Last Name	_____ Date of Birth	<input type="radio"/> M	<input type="radio"/> F
_____ Address	_____ City	_____ State	_____ Zip Code	_____ Phone	

<b>Primary</b>					
_____ Insurance Name	_____ Effective Date	_____ Employer			
_____ Insurance Address	_____ City	_____ State	_____ Zip Code	_____ Insurance Phone	
_____ (Subscriber) First Name	_____ M.I.	_____ Last Name	_____ Date of Birth		
_____ Social Security#	_____ Subscriber I.D. #	_____ Group#	_____ Relationship to Patient		
Subscriber's Address ( If different than patient)		<input type="checkbox"/> Is patient covered by another dental insurance plan? <input type="radio"/> Yes <input type="radio"/> No			
_____ Address	_____ City	_____ State	_____ Zip Code	_____ Phone	

<b>Secondary</b>					
_____ Insurance Name	_____ Effective Date	_____ Employer			
_____ Insurance Address	_____ City	_____ State	_____ Zip Code	_____ Insurance Phone	
_____ (Subscriber) First Name	_____ M.I.	_____ Last Name	_____ Date of Birth		
_____ Social Security#	_____ Subscriber I.D. #	_____ Group#	_____ Relationship to Patient		
Subscriber's Address ( If different than patient)					
_____ Address	_____ City	_____ State	_____ Zip Code	_____ Phone	

I hereby authorize payment of the dental benefits otherwise payable to me directly to the above named entity. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless 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 under applicable law, I authorize release of any information relating to this claim.

\_\_\_\_\_  
Signed (Subscriber/Parent)

\_\_\_\_\_  
Date