Insurance Information:

Name of Subscriber:

____

Last First Middle

Relation to Patient: Self______ Spouse______ Other______

If patient is not the subscriber, please complete the following information:

Address: _______________________________________ Home Phone: ______________

Number Street

City/State: ______________________________________ Zip Code: _________________

Business Phone: ____________________

Social Security Number: _______________ Date of Birth: _____________________________

Employer: ____

Primary Dental Insurance: (Please provide card if available)

Company: ________________________________ Phone #: ________________________

Address: ____

Group/ Policy #:_______________________ Subscriber ID#: ________________________

Primary Medical Insurance: (Please provide card if available)

Company: _______________________________ Phone #: _________________________

Address: ____

Group/Policy #: _______________________ Subscriber ID #: _________________________

Secondary Insurance: Dental________ Medical ________

Company: _______________________________ Phone #: _________________________

Address: ____

Group/Policy #: ______________________ Subscriber ID#: __________________________

I authorize the release of information relating to this claim. I authorize payment directly to Dr. Gulbransen/Dr. Recksiedler of the insurance benefits otherwise payable to me. I understand that I am ultimately responsible for all costs of treatment.

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Signature Date