Employment Information

The following is for ____ the patient's spouse ____ the person responsible for payment

Employer Name: _____ Occupation: _____
Address: _____

Insurance Information

Primary
Name of Insured: _____ Is insured a patient? _____
Insured's Birth Date: _____ ID# _____ Group# _____
Insured's Address: _____
Insured's Employer Name: _____
Address: _____
Patient's relationship to insured: ____ Self ____ Spouse ____ Child ____ Other
Insurance Plan Name and Address: _____
_____

Secondary
Name of Insured: _____ Is insured a patient? _____
Insured's Birth Date: _____ ID# _____ Group# _____
Insured's Address: _____
Insured's Employer Name: _____
Address: _____
Patient's relationship to insured: ____ Self ____ Spouse ____ Child ____ Other
Insurance Plan Name and Address: _____
_____

For office use only:

Eligibility Verified on ____ / ____ / ____ By _____ Contact: _____

Max _____ Deductible _____ Family _____ Waiting Period _____

Prevent _____ Basic _____ Major _____ Periodontics _____

Flouride _____ Inlay/Onlay _____ Pan/FMX _____ Prophy Frequency _____

Age Limits _____ Ortho _____ Implants _____ Other _____

Notes: _____

_____