

**WELCOME TO OUR OFFICE**

Patient's name \_\_\_\_\_  
Surname Given Name

A dental insurance policy is a contract between you and the insurance company. Our professional services are rendered and charged directly to the patient's account. The person responsible for the account is responsible for payment of all fees incurred. We will gladly assist you in submitting insurance claims pertaining to any charge for care in our office.

If you have more than one insurance carrier please indicate who is the primary insurance carrier. The primary carrier is the person whose birthday is first in the calendar year.

Primary Insurance

Secondary Insurance

\_\_\_\_\_  
Surname Given Name  
Address \_\_\_\_\_  
(If different from patient)  
City \_\_\_\_\_ Province \_\_\_\_\_  
Postal Code \_\_\_\_\_  
Phone \_\_\_\_\_ Work \_\_\_\_\_  
E-mail \_\_\_\_\_  
Birthday (M/D/Y) \_\_\_/\_\_\_/\_\_\_ Sex: M F

\_\_\_\_\_  
Surname Given Name  
Address \_\_\_\_\_  
(If different from patient)  
City \_\_\_\_\_ Province \_\_\_\_\_  
Postal Code \_\_\_\_\_  
Phone \_\_\_\_\_ Work \_\_\_\_\_  
E-mail \_\_\_\_\_  
Birthday (M/D/Y) \_\_\_/\_\_\_/\_\_\_ Sex: M F

Insurance Company \_\_\_\_\_

Insurance Company \_\_\_\_\_

Policy/ Plan # \_\_\_\_\_

Policy/ Plan # \_\_\_\_\_

Subscriber/Certificate # \_\_\_\_\_

Subscriber/Certificate # \_\_\_\_\_

Parent/Patient signature \_\_\_\_\_

Date \_\_\_\_\_