Dental Insurance Information

Please provide us with the following information:

Policyholder Name:	Relationship to Patient:
Policyholder Social Security# or Insurance ID#:	Policyholder Date of Birth:
Insurance Company Name and Address:	Employer or Group Name:
	Group Number:
Insurance Company Phone #:	

Signature on File

As a courtesy to our patients, we file your dental insurance. Please sign this form so that we may submit claims on your behalf.

- I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for the balance not covered by my insurance benefits.
- I authorize the release of information required to process my dental claim.

X_____

Patient/Parent or Guardian Signature Date

- I authorize and direct dental payments from my insurance company to be paid directly to Jack P. Horbal, DDS

X_____

Subscriber Signature Date