

INSURANCE INFORMATION

PRINT NAME OF PRIMARY  
*DENTAL INSURANCE COMPANY HERE* >>>

SUBSCRIBER'S NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

GROUP # \_\_\_\_\_ ID# \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_

PRINT NAME OF PRIMARY  
*MEDICAL INSURANCE: HERE* >>>

SUBSCRIBER'S NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

GROUP # \_\_\_\_\_ ID# \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_

SPECIALIST COPAY ON CARD \_\_\_\_\_

*I authorize the release of any dental or medical information necessary to process my claim and request payment of benefits directly to Dr. Martone for services provided. I understand that I am fully responsible for any portion of these services that are not covered by my insurance benefits.*

SIGN HERE \_\_\_\_\_ DATE \_\_\_\_\_

*PLEASE BE AWARE THAT THE HEALTH PROVIDER IS NOT RESPONSIBLE FOR OBTAINING PAYMENT FROM THE INSURANCE COMPANY. ALTHOUGH THE HEALTH PROVIDER WILL FILE A CLAIM AS A COURTESY TO THE PATIENT, OBTAINING PAYMENT FROM THE INSURANCE COMPANY IS ACTUALLY A MATTER BETWEEN THE PATIENT AND THE INSURANCE COMPANY AND THE RESPONSIBILITY OF THE PATIENT.*