ANDREW B. BROWN, DDS
INSURANCE INFORMATION

PATIENT NAME: ____

DATE OF BIRTH: ____

PRIMARY

SUSCRIBERS NAME: ____________________ SS # ________________________
DATE OF BIRTH: _________________________
RELATIONSHIP: _____________________
EMPLOYER: ____
INSURANCE: ____

OFFICE USE ONLY

SPOKE WITH: ______________________ DATE: __________________________
EFFECTIVE DATE: __________________
BENEFITS QUOTED FAXED
MAX: _____________ % _________________ DED ____________ USED ________

RECERT: AUTO MONTHLY QUARTERLY ANNUALLY

SECONDARY

SUSCRIBERS NAME: ____________________ SS # ________________________
DATE OF BIRTH: _________________________
RELATIONSHIP: _____________________
EMPLOYER: ____
INSURANCE: ____

OFFICE USE ONLY

SPOKE WITH: ______________________ DATE: __________________________
EFFECTIVE DATE: __________________
BENEFITS QUOTED FAXED
MAX: _____________ % _________________ DED ____________ USED ________

RECERT: AUTO MONTHLY QUARTERLY ANNUALLY

** I have reviewed the treatment plan, I authorize release of any information relating to this claim and hereby authorize payment directly to the above named dentist of the group insurance benefits otherwise payable to me.

_____________________________ _____________________________
PRIMARY INSURED SIGNATURE SECONDARY INSURED SIGNATURE