DENTAL INSURANCE INFORMATION

WESTERN RESERVE PERIODONTICS
Periodontics and Implant Surgeries

Name and Address of Insurance Company

Patient Name (first m.i. last)	Sex m / f	Patient Birthdate MM / DD / YY	Relationship to insured ☐Self ☐Child ☐Spouse ☐Other_____	If full time student School

Insured's Name and Address	Insured's social security or certificate number	Insured's Birthdate MM / DD / YY	Insured's place of employment	Policy group #

Is patient covered by another dental plan? ☐yes ☐no If yes, please complete the following:

Name and address of secondary insurance company	Secondary policy holder's name and address

Secondary's social security or certificate #	Secondary's birthdate MM / DD / YY	Secondary's place of employment	Policy group number	Relationship to patient: ☐Self ☐Parent ☐Spouse ☐Other_____

***** SIGN BELOW *****

I authorize release of any information relating to claims submitted. I understand that I am responsible for all costs of dental treatment.	I hereby authorize payment of dental benefits otherwise payable to me directly to Western Reserve Periodontics, Inc.
✖ _____ Signed (patient, or parent if minor) _____ Date	✖ _____ Signed _____ Date

Rev 02/01