DENTAL INSURANCE INFORMATION

Lance W. Crawford, DDS • Jonathan F. Crawford, DDS
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Patient Name: ______________________________

PRIMARY Dental Insurance

Name of Subscriber: ______________________________

Insured's ID #: ____________________ Subscriber Birthdate: ___/___/___

Insured's Group # (if available): ______________________________

Subscriber's Employer: ______________________________

Insurance Company Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

SECONDARY Dental Insurance

Name of Subscriber: ______________________________

Insured's ID #: ____________________ Insured's Birthdate: ___/___/___

Insured's Group # (if available): ______________________________

Insured's Employer: ______________________________

Insurance Company Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

I hereby accept the below treatment and authorize release of any information to this claim. I request the payment of authorized benefits be made on my behalf if I pay in full or I assign the benefits to which I am entitled to this practice. This assignment will remain in effect until revoked by me in writing.

A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges rendered, whether or not paid by an insurance carrier, and balances over 30 days will be charged a monthly service charge fee (1.5% interest) for each month the balance is carried.

______________________________ Date: ____________

Patient Signature (or Guardian if Patient is a Minor)