small&martin ORTHODONTICS

INSURANCE INFORMATION

Subscriber name _____ Birthdate _____
Last Name First Name Middle Int.

Relation to patient: _____ Subscriber Soc. Sec. Number _____

Subscriber Address:(If different than pt) _____ Phone # _____

City _____ State _____ Zip _____

Insured employed by _____ Phone # _____

Insurance Company _____ Phone # _____

Group# _____ Subscriber ID# _____

ADDITIONAL INSURANCE INFORMATION..... Is patient covered by additonal insurance ___YES ___NO

Subscriber name _____ Birthdate _____

Relation to patient: _____ Subscriber Soc. Sec. Number _____

Subscriber Address:(If different than pt) _____ Phone # _____

City _____ State _____ Zip _____

Insured employed by _____ Phone # _____

Insurance Company _____ Phone # _____

Group# _____ Subscriber ID# _____

I, the undersigned certify that I or my dependants have insurance coverage with the above mentioned Insurance Companies and assign directly to Dr. David C. Small all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to relase all informatin necessary to secure payment of benfits. I authorize the use of this signature on all insurance submissions. _____

Insured-Responsible Party Signature DATE