

INSURANCE INFORMATION

PATIENT'S NAME : _____

PRIMARY INSURANCE INFORMATION

Is the insurance policy under patient's own name ? Yes [] No []

If not, what is the Policy holder's name?

Last Name : _____ First Name : _____

Relationship to patient : Spouse [] Parent []

Policy Holder's Date of Birth (dd/mm/yyyy): _____/_____/_____

Policy Holder's Employer : _____ Tel : _____

Name of Insurance Company : _____

Group Policy/Plan/Contract # : _____ Division # : _____

Cert./SIN/Employee # : _____ Account # : _____

Does your plan have any deductible ? Yes [] No [] If yes, how much ? _____

Percentage (%) coverage : _____%

Based on which year's Ontario Dental Association Fee Guide ? _____

Starting and ending date of insurance benefit: _____

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

Name of Policy Holder: Last Name : _____ First Name : _____

Relationship to patient : Spouse [] Parent []

Policy Holder's Date of Birth (dd/mm/yyyy): _____/_____/_____

Policy Holder's Employer : _____ Tel : _____

Name of Insurance Company : _____

Group Policy/Plan/Contract # : _____ Division # : _____

Cert./SIN/Employee # : _____ Account # : _____

Starting and ending date of insurance benefit: _____

I authorize release, to my insuring company plan administrator, the information contained in claims submitted electronically. Signature of Primary Policy Holder: _____

(Please sign if you would like to take advantage of our electronic claim submission service. Thank you.)