Phillip Roe, DDS, MS
Fixed Prosthodontics and Implant Surgery

INSURANCE INFORMATION (DENTAL COVERAGE ONLY)

INSURANCE COMPANY #1_____

INSURANCE COMPANY ADDRESS_____

_____ _____

POLICY HOLDER_____

BIRTHDATE OF POLICY HOLDER_____

SOCIAL SECURITY OR I.D. NUMBER OF POLICY HOLDER_____

GROUP POLICY NUMBER_____

EMPLOYER_____

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INSURANCE COMPANY #2_____

INSURANCE COMPANY ADDRESS_____

_____

POLICY HOLDER_____

BIRTHDATE OF POLICY HOLDER_____

SOCIAL SECURITY OR I.D.NUMBER OF POLICYHOLDER_____

GROUP POLICY NUMBER_____

EMPLOYER_____

We are happy to bill your insurance company for your dental treatment and let them know they should assign benefits to the subscriber. You are required to provide us with the necessary information to bill your insurance company. It is your responsibility to know the extent of your insurance benefits, restrictions, and limitations.

SIGNATURE_____ DATE_____