DRS ENSOR JOHNSON & LEWIS

Insurance Information Form

Please present your insurance card to the front desk with this completed form.

Patient Name:_____

Policy Holder Name and DOB:_____

Policy Holder Insurance ID/SS#:_____ Group #:_____

Relationship to Patient:_____

Insurance Company Name:_____

Employer:_____

Insurance Co. Phone Number:_____

Insurance Co. Claims Address:_____

_____

I have reviewed the treatment plan. I authorize the release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment that my insurance plan does not cover.

Patient Signature:_____ Date:_____

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