DRS ENSOR JOHNSON & LEWIS

Insurance Information Form

Patient(s) Name:_____

Subscriber Name:_____

Subscriber DOB:_____

Subscriber SS#:_____

Subscriber Insurance ID:_____Group #:_____

Relationship to Patient:_____

Insurance Company Name:_____

Employer:_____

Insurance Co. Phone Number:_____

Insurance Co. Claims Address:_____

_____

Plan Start Date: _____

Does this insurance plan replace the insurance that we currently have on file? Yes. No.

Is this insurance (circle one): Dental Medical with pediatric dental

Do you have secondary insurance? If so, please ask the receptionist for a second form.

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:_____

The Dental Practice of Drs Ensor Johnson & Lewis
11810 Parklawn Drive, Suite 101, North Bethesda, MD 20852
(P) 301-881-6170 ● (F) 301-231-9659 ● info@ejldental.com ● www.ejldental.com