Five Points
FAMILY DENTISTRY

Date:______________

Patient Name:_________________________________**DOB**:________________________

Address:__________________________________**City**:____________**State**:________**Zip**:_________

Dental Insurance Information

1 Insurance Subscriber	2 Relationship	3 Sub. DOB
4 Employer Name and Address	5 ID#	6 Policy/Group #
7 Dental Insurance Co.	8 Address	9 Dental Insurance Phone #

Do you have Secondary Coverage? YES / NO If yes, please fill out boxes 10-18 below

10 Insurance Subscriber	11 Relationship	12 Sub. DOB
13 Employer Name and Address	14 ID#	15 Policy/Group #
16 Dental Insurance Co.	17 Address	18 Dental Insurance Phone #

I understand that I am responsible for the cost of this care regardless of insurance coverage and deductibles. I authorize the release of information as it relates to my dental treatment and my insurance coverage. I also acknowledge that I have received a copy of the office "Privacy Policy" as required by the Health Insurance Portability & Accountability Act (HIPPA).

Signature__________________________________**Date**________________