

Maitland Family Dentistry

Insurance Information

We are happy to work with all insurances. Please provide necessary information below.
All information is completely confidential.

Insurance Holder's Name Sex Birthday Soc. Sec. #

Spouse's Name Sex Birthday Soc. Sec. #

Dependent's Name (last name if different than yours) Sex Birthday

1.

2.

3.

4.

Insurance Holder's Employment _____

Insurance Company Name Address City State Zip

Any numbers that may be required (such as: Group #, Employee #, etc.)

If you have additional coverage, please complete below.

Insurance Holder's Name Sex Birthday Soc. Sec. #

Employment _____

Insurance Company Name Address City State Zip

Any numbers that may be required (such as: Group #, Employee #, etc.)

- **I authorize release of any information relating to my claim.**
- **I authorize payment directly to Maitland Family Dentistry**
- **I understand that all fees not paid by insurance are my responsibility.**

Signature _____

Witness _____ Date _____

Note: If you have an insurance card, please give it to the receptionist so she can make a photocopy which will help in speeding your insurance claim.