

Insurance Information

	<u>1st Insurance Co.</u>	<u>2nd Insurance Co.</u>
Employee's Name	_____	_____
Social Security No.	_____	_____
Sex	_____	_____
Date of Birth	_____	_____
Insurance Co. Name	_____	_____
Insurance Co. Address	_____	_____
Insurance Co. Phone	_____	_____
Group Plan Number	_____	_____
Local Union Number	_____	_____
Policy Number (or BIC #)	_____	_____
Employer's Name	_____	_____
Employer's Address	_____	_____
	_____	_____
Family Members Covered	_____	_____

EAST ISLIP DENTAL CARE WILL ASSIST YOU IN EVERY WAY POSSIBLE WITH YOUR INSURANCE CARRIER; HOWEVER, IT IS NOT ALWAYS POSSIBLE TO PREDICT WHICH SERVICES ARE COVERED BY THE CARRIER OR HOW MUCH THEY WILL PAY FOR A PARTICULAR SERVICE. PLEASE CONTACT YOUR INSURANCE CARRIER WITH ANY QUESTIONS REGARDING YOUR COVERAGE. PATIENTS WITH INSURANCE ARE RESPONSIBLE FOR PAYMENT OF THEIR BILLS.

Patient Signature: _____

Date: _____