RECORD RIDGE DENTURE CLINIC

INSURANCE INFORMATION FORM

INSURANCE INFORMATION			
Primary Insurance Provider			
Please indicate primary insurance company:			
Subscriber's name:	ID no.:		Policy no.:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	Subscriber's birth date:
Secondary Insurance Provider			
Name of secondary insurance (if applicable):			
Subscriber's name:	ID no.:		Policy no.:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	Subscriber's birth date:

CONSENT	
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the denturist and I understand that I am financially responsible for any balance. I authorize Record Ridge Denture Clinic to release any information required to process my claims. I also authorize a $65.00 insurance submission fee payable to the denturist.	
Patient signature	*Date*