

INSURANCE INFORMATION

Name of person who holds ins: _____
Birth date: _____ SS#: _____
(if given) Ins. Id#: _____
Employer: _____
City: _____ State: _____
Work telephone#: _____

Dental ins carrier: _____
Claim mailing address: _____

Customer service ph#: _____
Group#: _____ Effective date: _____

Members covered by ins. Policy:

Spouse: _____	Birth date: _____
Dependent: _____	Birth date: _____
Dependent: _____	Birth date: _____
Dependent: _____	Birth date: _____

If dependent is a full time student at a Univ. Or college:

Student: _____	Where: _____
Student: _____	Where: _____

Are any family members covered by other plan? _____

If so whom? _____

Do we already have ins info? _____

CREDIT CARD AUTHORIZATION

I, _____, authorize **SAVIN DENTAL ASSOCIATES** to charge my credit card to pay any amount due (for \$250.00 or less) after my insurance payments are received.

Credit card #: _____
Expiration date: _____ Authorization code: _____
Billing zip code: _____
Signature: _____

Savin dental associates fax#: (847) 835-0905