Date:________________

INSURANCE INFORMATION

POLICY HOLDER'S NAME________________________________
Birth date ________________ SS# __________________________________
POLICY or ID# ___________________________________
EMPLOYER: ____
Work phone # ______________________________

DENTAL INS. CARRIER ____
Claim mailing address ____
____
Customer service phone # ______________________________________
GROUP # ______________________ effective date ___________________
PAYOR ID# _____________________

MEMBERS COVERED BY INS POLICY:
Spouse ___________________________ Birth date___________________
Dependent _________________________ Birth date___________________
Dependent _________________________ Birth date___________________
Dependent _________________________ Birth date___________________
IS THIS PEDIATRIC COVERAGE ONLY? ___________

IS THERE A SECONDARY INSURANCE CARRIER? __________

DO YOU HAVE AN ORTHODONTIC ACCOUNT WITH US? _______

CREDIT CARD AUTHORIZATION (optional)

I, ______________________________________, authorize **SAVIN DENTAL ASSOCIATES** to charge my credit card for any amount due ($250.00 or less) after my insurance has responded.

CREDIT CARD# ____
Expiration date __________________ Authorization code ________________
Billing zip code ________________

SIGNATURE:____

Savin Dental Associates **FAX #: (847) 835-0905**
E-MAIL: info@SavinDentalGroup.com