# PATIENT INSURANCE INFORMATION

Last Name:_____ First Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone Number:_____ Work Number_____

Employer:_____ Marital Status:_____

## RESPONSIBLE PARTY- PRIMARY INSURANCE INFORMATION

Last Name:_____ First Name:_____

Date of Birth:_____ Relationship to Patient:_____

Address:_____

Employer:_____ Address:_____

Home Number:_____ Work Number:_____

Insurance Company:_____ Address:_____

Insurance Phone Number:_____ Id Number:_____

Social Security Number:_____ Group Number:_____

## RESPONSIBLE PARTY- SECONDARY INSURANCE INFORMATION

Last Name:_____ First Name:_____

Date of Birth:_____ Relationship to Patient:_____

Address:_____

Home Number:_____ Work Number:_____

Employer:_____ Address:_____

Insurance Company:_____ Address:_____

Social Security Number:_____ Group Number_____

I hereby authorize the release of any information acquired in the course of my examination and treatment to insurance companies and referring dentist. I also authorize payment of dental benefits to Dr. Rachel H Naylor, D.M.D., MS when insurance payments are involved.

Signature:_____ Date_____