# NORTH BELLMORE DENTAL ASSOCIATES, P.C.

FOR PATIENTS WITH DENTAL INSURANCE

**PRIMARY** INSURANCE COMPANY: _____

INSURED PERSON (EMPLOYEE):_____

RELATIONSHIP TO PT.: SELF _____ SPOUSE_____ CHILD_____

GROUP NAME OR NUMBER: _____ EMPLOYEE SS# _____

EMPLOYER ADDRESS: _____
HOUSE # & STREET CITY OR TOWN STATE ZIP

INS. CO. ADDRESS: _____

INS. CO. PHONE: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

**SECONDARY** INSURANCE COMPANY: _____

INSURED PERSON (EMPLOYEE):_____

RELATIONSHIP TO PT.: SELF _____ SPOUSE_____ CHILD_____

GROUP NAME OR NUMBER: _____ EMPLOYEE SS# _____

EMPLOYER ADDRESS: _____
HOUSE # & STREET CITY OR TOWN STATE ZIP

INS. CO. ADDRESS: _____

INS. CO. PHONE: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

I UNDERSTAND THAT EVEN THOUGH I MAY HAVE DENTAL INSURANCE COVERAGE, I AM RESPONSIBLE FOR FULL PAYMENT OF SERVICES.

_____ _____

(date) (signature of patient, parent, or guardian)