INSURANCE INFORMATION FORM

DRS. LARSON MARTYN & HAFNER, LLP

PATIENT NAMES(S): _____

PRIMARY INSURANCE

SUBSCRIBER NAME: _____ BIRTHDATE: _____

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ SOCIAL SECURITY NO: _____ RELATION TO PATIENT: _____

EMPLOYER NAME: _____ PHONE: _____

EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INSURANCE COMPANY NAME: _____ PHONE: _____

INSURANCE ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

GROUP NUMBER: _____ I.D. NUMBER: _____

EFFECTIVE DATE: _____

I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information relating to insurance claimes submitted on my behalf. I also authorize payment directly to Dr. Larson, Martyn, and Hafner, LLP of the group insurance benefits otherwise payable to me.

SIGNATURE: _____ DATE: _____

SECONDARY INSURANCE

SUBSCRIBER NAME: _____ BIRTHDATE: _____

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ SOCIAL SECURITY NO: _____ RELATION TO PATIENT: _____

EMPLOYER NAME: _____ PHONE: _____

EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INSURANCE COMPANY NAME: _____ PHONE: _____

INSURANCE ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

GROUP NUMBER: _____ I.D. NUMBER: _____

EFFECTIVE DATE: _____

I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information relating to insurance claimes submitted on my behalf. I also authorize payment directly to Dr. Larson, Martyn, and Hafner, LLP of the group insurance benefits otherwise payable to me.

SIGNATURE: _____ DATE: _____