ACADIA FAMILY DENTISTRY

## Insurance
# Information Release Form

### Policy Holder's Information

| | | | |
|---|---|---|---|
| | ❑ Male ❑ Female | / / | - - |
| Policy Holder's Name | | Birthday | Social Security Number |
| | ❑ Male ❑ Female | / / | - - |
| Spouses Name | | Birthday | Social Security Number |

### Dependent's Name (last name if different than yours)

| | | | |
|---|---|---|---|
| | ❑ Male ❑ Female | / / | - - |
| Dependent | | Birthday | Social Security Number |
| | ❑ Male ❑Female | / / | - - |
| Dependent | | Birthday | Social Security Number |
| | ❑ Male ❑ Female | / / | - - |
| Dependent | | Birthday | Social Security Number |
| | ❑ Male ❑Female | / / | - - |
| Dependent | | Birthday | Social Security Number |

### Insurance Information

| | | | | |
|---|---|---|---|---|
| Employer | Address | City | Zip | Phone Number |
| Insurance Company | Address | City | Zip | Phone Number |

| | | |
|---|---|---|
| ID Number | Group Number | Plan Number |

### Secondary Insurance Information

| | | | |
|---|---|---|---|
| | ❑ Male ❑ Female | / / | - - |
| Policy Holder's Name | | Birthday | Social Security Number |

| | | | | |
|---|---|---|---|---|
| Employer | Address | City | Zip | Phone Number |
| Insurance Company | Address | City | Zip | Phone Number |

| | | |
|---|---|---|
| ID Number | Group Number | Plan Number |

Please Initial:
_____ I authorize release of any information relating to my claim.
_____ I authorize payment directly to [insert doctor or practice's name].
_____ I understand that all fees not paid by insurance are my responsibility.

| | | |
|---|---|---|
| Print Patient Name | Patient Signature | Date |

Employee Signature

Note: If you have an insurance card, please give it to the receptionist so she can make a photocopy which will help in speeding your insurance claim.