Secondary Insurance

Patient Name:________________________

Secondary Insurance:

Secondary Insurance Company	
Group No.	ID No.

Insurance Subscriber Information:

Name	Home Address	City, State, Zip
Home Phone	Social Security No.	Birthdate
Cell Phone	Driver's License No.	Sex(Circle One): Male Female
Work Phone	Email	Relation to Patient:
Employer	Marital Status (circle one): Single Married Divorced Other	Occupation

As a courtesy to me, I understand this office will file any dental insurance for me. I hereby authorize release of any information needed and also authorize my insurance company to pay directly to this office benefits accruing under my policy. If the insurance company does not pay I understand I am responsible for the remaining portion.

I understand secondary insurance can take 2-3 times longer to process, since it requires payment from my primary policy first. I understand in some instances due to my insurance I may have to pay a portion and wait for insurance to reimburse me.

☐ **I have read the above conditions about my insurance and agree to their content.**

____ ____________

Patient/Parent/Guardian Signature (Responsible Party) Date

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Relationship to Patient