SIOUX CITY 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.