Stephen L. Meyer, D.D.S.
M. Katherine Anderson, D.D.S.

Comprehensive Dentistry with Care

Insurance Information Form

Patient Name: _____ Sex: M / F

Address: _____Zip code_____

Social Security Number: _____ DOB: _____

If Full Time Student: School_____ City _____

Primary Dental Insurance Coverage

Policy Holder: _____ Relation to Patient: _____

Address: _____

Employer: _____

INS ID# _____ DOB: _____

Insurance Co: _____Group # _____

Insurance Co Phone Number: _____

Secondary Dental Insurance Coverage

Policy Holder: _____ Relation to Patient: _____

Address: _____

Employer: _____

INS ID# _____ DOB: _____

Insurance Co: _____Group # _____

Insurance Co Phone Number: _____

To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____ Date: _____
Patient/Guardian signature

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the above named dentist or dental entity.

X _____ Date: _____
Subscriber or **Patient**/Guardian signature