EAU CLAIRE PERIODONTICS
3902 Oakwood Hills Pkwy, Suite 2
Eau Claire, WI 54701

INSURANCE INFORMATION

Patient Name: _____

DENTAL

PRIMARY DENTAL
Subscriber Name: _____
Subscriber Employer: _____
Name of Insurance Co: _____
Subscriber ID or SS#: _____
Group Number: _____
Subscriber Birthdate: _____

SECONDARY DENTAL
Subscriber Name: _____
Subscriber Employer: _____
Name of Insurance Co: _____
Subscriber ID or SS#: _____
Group Number: _____
Subscriber Birthdate: _____

MEDICAL

PRIMARY MEDICAL
Subscriber Name: _____
Subscriber Employer: _____
Name of Insurance Co: _____
Subscriber ID or SS#: _____
Group Number: _____
Subscriber Birthdate: _____

SECONDARY MEDICAL
Subscriber Name: _____
Subscriber Employer: _____
Name of Insurance Co: _____
Subscriber ID or SS#: _____
Group Number: _____
Subscriber Birthdate: _____

Your insurance cards will be scanned upon completion of this form.

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INSURANCE AUTHORIZATION

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO EAU CLAIRE PERIODONTICS, LLC OF THE DENTAL/MEDICAL BENEFITS OTHERWISE PAYABLE TO ME.

Eau Claire Periodontics, LLC is authorized to provide any insurance company(s) and consulting health care professionals information concerning health care, advise, treatment or supplies provided. This information will be used for the purpose of evaluating and administering claims for benefits.

I know I have a right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

X_____
Patient or authorized person's signature Date