OFFICE USE ONLY:

Effective Date: ______________________________Deductible:________________

Yr. Max: ______________________ Prior Hx: __________________________

Frequency Limitations: Bwx: ____________________ Pan: _______________

Seals: _____________________________________Fl: _________________

In order for our office to file your insurance you must provide the following information, and a copy of your current dental insurance card. (Please Print)

Patient's Name: __________________________________Birthdate:_____________

1. **Insurance Company Name: ____**
2. **Insurance Company Address: ______________________________________**

   ____
3. **Insurance Company Phone Number: ________________________________**
4. **Employer Name: ____**
5. **Insured's Full Name: ____**
6. **Insured's Date of Birth: ____**
7. **Insured's Social Security Number: ___________________________________**
8. **Insured's ID number (if different): __________________________________**
9. **Plan/Policy Group Number: ____**

I authorize payment to Greenville Pediatric Dentistry P. A. for the dental procedures submitted. I hereby acknowledge responsibility for any cost incurred not covered by my insurance company.

Signature: ____________________________________ Date: ______________