

**STATE OF THE ART DENTAL GROUP
INSURANCE INFORMATION**

Please present insurance card with completed form.

Patient Name _____

Patients SS# _____ - _____ - _____ Patients D.O.B. _____

Insurance Company Name _____

Ins. Co. Phone # _____ Group# _____ ID# _____

Ins. Co. Address _____

Policy Holders Name _____

Policy Holders Employer _____

Policy Holders SS# _____ - _____ - _____ Policy Holders D.O.B. _____

By signing below I authorize the release of any insurance information to be used to obtain payment for services. I understand that I am responsible for any remaining balance not payable by my insurance company.

X _____ Date _____