INSURANCE INFORMATION

Primary Dental Insurance

Insurance Subscriber (circle one): Patient Spouse Other
(if "other" please provide the Name, SS#, & date of birth)

Name _____ SS#_____ Date of Birth _____

Insured's Employer _____ Insurance Company_____

Insurance Phone #_____ Insurance Company Address _____

Group/Policy #_____ Effective Date _____

Secondary Dental Insurance

Insurance Subscriber (circle one): Patient Spouse Other
(if "other" please provide the Name, SS#, & date of birth)

Name _____ SS#_____ Date of Birth _____

Insured's Employer _____ Insurance Company_____

Insurance Phone #_____ Insurance Company Address _____

Group/Policy #_____ Effective Date _____

Please Note: The submission of claims to any additional insurances other than those above is the responsibility of the patient and not of South Lyon Dental Care Center. Should the above information change, the patient is to notify South Lyon Dental Care Center promptly. South Lyon Dental Care Center is not responsible for any late or unpaid claims due to incomplete information or untimely notification of changes on the part of the patient.

EMERGENCY NOTIFICATON INFORMATION
In case of emergency, please provide information of two people that we can notify.

Name _____ Relationship_____
Last First Middle

Address _____ Phone # ( )_____

Name _____ Relationship_____
Last First Middle

Address _____ Phone # ( )_____

FOR ALL PATIENTS
I hereby authorize the staff of South Lyon Dental Care Center to perform any and all treatment that may be indicated in connection with the dental care of the above patient. I agree to be responsible for payment of all services rendered. I authorize this office to release any information necessary to expedite billing and/or collecting such payments. I also authorize payment of any insurance benefits due me directly to Paul L. Simon, D.D.S. PLC

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Signature of Responsible Party Today's Date