

FAMILY DENTAL INSURANCE UPDATE

Subscriber's Name _____ Subscriber's Soc. Sec. # _____

Subscriber's Employer _____ Ph. # _____

Insurance Company _____ Group # _____

Insurance Co. Address _____ Ph. # _____

Is policy connected with your union? Yes No Name of union _____ Local # _____

Insured Dependents:

Spouse: _____ Birthdate _____

Children/Others: _____ Birthdate _____

_____ Birthdate _____

_____ Birthdate _____

_____ Birthdate _____

_____ Birthdate _____

_____ Birthdate _____

Do you have dual coverage? Yes No If yes: **Please complete the following secondary insurance information.**

Subscriber's Name _____ Subscriber's Soc. Sec. # _____

Subscriber's Employer _____ Ph. # _____

Insurance Company _____ Group # _____

Insurance Co. Address _____ Ph. # _____

Is policy connected with your union? Yes No Name of union _____ Local # _____

Insured Dependents:

Spouse: _____ Birthdate _____

Children/Others: _____ Birthdate _____

_____ Birthdate _____

_____ Birthdate _____

_____ Birthdate _____

_____ Birthdate _____

_____ Birthdate _____

I, the undersigned, assign directly to Richard D. Freiboth, D.D.S., all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signature _____ Date _____