CDAnet Patient Information Form

Insurance Information

PRIMARY INSURANCE INFORMATION

Name of patient: ____

Name of policy holder: ____

Policy Holder's Date of Birth (dd/mm/yyyy): ______________________________

Insurance Company: ____

Policy/Group Number: ____

Subscriber/Certificate Number: ______________________________________

Place of employment: ____

Relationship of patient to policy holder: ❑ Self ❑ Dependant ❑ Spouse

Are you claiming from more than one insurance company? ❑ Yes ❑ No

If yes, please complete the following:

IS THIS AN ACCIDENT CLAIM ❑ YES ❑ NO

ACCIDENT CLAIM #____

SECONDARY INSURANCE INFORMATION

Name of policy holder: ____

Policy Holder's Date of Birth (dd/mm/yyyy): ______________________________

Insurance Company: ____

Policy/Group Number: ____

Subscriber/Certificate Number: ______________________________________

Place of employment: ____

Relationship of patient to policy holder: ❑ Dependant ❑ Spouse

AUTHORIZED CONSENT TO RELEASE INFORMATION

I authorize release to my dental benefits plan administrator, information contained in claims submitted electronically.

I also understand that Dr. Peter Fritz's office is a non-assignment office (all reimbursement cheques will be sent to the insurance subscriber), and that I am personally responsible for payment of my account.

______________________________ ______________________

Signature of patient/parent/guardian Date