Steven R. Zembroski, DMD

INSURANCE INFORMATION

Today's Date: _____

Patient's Name: _____

Parent/Guardian (if under 18): _____ Relation: _____

PRIMARY DENTAL INSURANCE	*SECONDARY DENTAL INSURANCE*
	Are you covered by additional insurance? Yes No
Subscriber: _____	Subscriber: _____
Subscriber's Date of Birth: _____	Subscriber's Date of Birth: _____
Subscriber's SSN: _____	Subscriber's SSN: _____
Relationship to Patient: _____	Relationship to Patient: _____
Insurance Co: _____	Insurance Co: _____
Ins. Address: _____	Ins. Address: _____
_____	_____
Phone # _____	Phone # _____
Group #: _____ ID#: _____	Group #: _____ ID#: _____
Employer: _____	Employer: _____
Electronic #: _____	Electronic #: _____
Family members covered: _____	Family members covered: _____
_____	_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage as listed above and assign directly to Dr. Steven Zembroski all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am finacially 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 in all insurance submissions.

_____ _____ _____

Responsible Party Signature Relationship Date

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