Patrick J. Sabo, D.M.D.

Mark A. Rienecker, D.D.S., P.C.

DENTAL INSURANCE INFORMATION

(PLEASE PRESENT YOUR DENTAL INSURANCE CARD)

PATIENT NAME:_____**D.O.B**._____

PRIMARY DENTAL INSURANCE COMPANY NAME:_____

DENAL INSURANCE COMPANY

ADDRESS:_____

DENTAL INSURANCE COMPANY PHONE NUMBER:_____

EMPLOYER:_____**EMPLOYER ADDRESS:**_____

NAME OF POLICY HOLDER:_____**SS#**_____

HOME ADDRESS:_____

INSUREDS ID #_____**POLICY HOLDER'S DATE OF BIRTH:**_____

GROUP #_____**RELATIONSHIP TO INSURED:**_____

SECONDARY DENTAL INSURANCE COMPANY

NAME:_____

DENTAL INSURANCE COMPANY

ADDRESS:_____

DENTAL INSURANCE COMPANY PHONE NUMBER:_____

EMPLOYER:_____**EMPLOYER ADDRESS:**_____

NAME OF POLICY HOLER:_____**SS#**_____

HOME ADDRESS_____

INSUREDS ID #_____**POLICY HOLDER'S DATE OF BIRTH:**_____

GROUP #_____**RELATIONSHIP TO INSURED:**_____

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agencies for the purpose of obtaining payment for services and determining dental insurance benefits payable for related services.

Signature Date