

DENTAL INSURANCE INFORMATION

Primary Dental Insurance Company

Insurance Company Name _____ Employer _____
Insurance co. Address _____ Insurance Co. _____
City _____ State _____ Telephone # _____
Insurance Subscriber's Name _____ DOB ____/____/____
Insurance Subscriber ID # _____ Plan or Group #: _____ Local: _____
School attended full time by dependents over 19 years old : _____

If you are not the primary card holder please complete the following:

Primary Card Holder's Name: _____
Primary Card Holder's Birth Date: _____ Soc Sec # _____
Employer _____ No. Years Employed _____
Work Phone _____ Relation _____

Assignment of Benefits

I authorize payment of benefits to Dr. Varsha Gogate-Bhuyan, DMD
For dental services provided.

Release of Information

I authorize the release of any dental
information necessary to process claims

Signature **Date**

Signature **Date**

If you have double dental insurance coverage, complete this for the second coverage:

Secondary Insurance Company

Insurance Company Name _____ Employer _____
Insurance co. Address _____ Insurance Co. _____
City _____ State _____ Telephone # _____
Insurance Subscriber's Name _____ DOB ____/____/____
Insurance Subscriber ID # _____ Plan or Group #: _____ Local: _____
Family members covered under this plan: _____
School attended full time by dependents over 19 years old : _____

If you are not the primary card holder please complete the following:

Primary Card Holder's Name: _____
Primary Card Holder's Birth Date: _____ Soc Sec # _____
Employer _____ No. Years Employed _____
Work Phone _____ Relation _____

Assignment of Benefits

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