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IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE:

Insurance Company _____

Policy or Group Number _____ Name of POLICY HOLDER _____

ID# of POLICY HOLDER _____ Date of birth of POLICY HOLDER _____

Certificate Number _____ Division Number _____ Dependent Number _____

Percentage Coverage: Basic _____ Major _____ Ortho _____

Annual Limit _____ Annual Deductible _____

Name of Employer _____

Are you covered by a second dental insurance company? (Dual Coverage] Yes ☐ No ☐

IF YOU HAVE DUAL COVERAGE, PLEASE COMPLETE:

Insurance Company _____

Policy or Group Number _____ Name of POLICY HOLDER _____

ID# of POLICY HOLDER _____ Date of birth of POLICY HOLDER _____

Certificate Number _____ Division Number _____

Percentage Coverage: Basic _____ Major _____ Ortho _____

Annual Limit _____ Annual Deductible _____

Name of employer _____

INSURANCE

On your behalf, our office will correspond with your insurance company for your dental benefit reimbursement. The patient is responsible for all fees.

I hereby authorize Dr. Scott Yamaoka to electronically submit claims on my behalf and submit the necessary documentation to my insurance company.

_____ _____

SIGNATURE OF SUBSCRIBER **DATE**