TOWSON ENDODONTICS
Practice Limited to Endodontics & Microsurgery

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PATIENT INSURANCE AGREEMENT

Please Print All Information

This statement validates that you understand that any co-pays or fees given to you on the phone or in the office are ***ESTIMATES*** only. You may be responsible for further payment after the insurance has been submitted and payment has been received.

_____
Signature

NAME OF PATIENT: _____ Patient Date of Birth: ___/___/____

PRIMARY DENTAL INSURANCE

Name of Insurance Company & Phone Number:_____

Name of Subscriber: _____

Subscriber's Social Security Number: ____ - ____ - ____ Subscriber Date of Birth: ___/___/____

Address of Subscriber: _____

Subscriber's Employer: _____

Relationship to Patient:_____

SECONDARY DENTAL INSURANCE

(if applicable)

Name of Insurance Company & Phone Number: _____

Name of Subscriber: _____

Subscriber's Social Security Number: ____ - ____ - ____ Subscriber Date of Birth: ___/___/____

Address of Subscriber: _____

Subscriber's Employer: _____

Relationship to Patient:_____