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.

_____ _____
Patient Name Date

Name of Patient: _____ Patient Date of Birth: ___/___/____

Name of Policy Holder: _____

Address of Policy Holder: _____

Policy Holder Social Security Number: ____ - ____ - ____ Policy Holder Date of Birth: ___/___/____

Name of Insurance Company & Phone Number: _____

Policy Holder's Employer: _____

## IF THERE IS A SECONDARY INSURANCE, PLEASE PROVIDE THE FOLLOWING INFORMATION

Name of Insurance Company & Phone Number: _____

Name of Policy Holder: _____

Policy Holder Social Security Number: ____ - ____ - ____ Policy Holder Date of Birth: ___/___/____

Address of Policy Holder: _____

Relationship to Patient: _____