Granite State Endodontics

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DENTAL INSURANCE INFORMATION.

Date__________________ **Patient Name:**____________________________________

Primary Dental Carrier,______________________________ **Phone #**__________

Insurance Address____

Policy Holder's Name____________________________ **Date of Birth**____________

Subscriber I.D. ________________________________ **Group #** __________________

Place of Employment ______________________________________

Secondary Dental Insurance Carrier, (if applicable)

Insurance Address ______________________________________ **Phone #** __________

Policy Holder's Name ______________________________ **Date of Birth** __________

Subscriber's I.D. __________________________________ **Group #** ______________

Place of Employment____

**** **PLEASE NOTE:** As a courtesy to our patients we will call your Insurance Company regarding your Endodontic benefits for this procedure.

THE AMOUNT QUOTED TO YOU IS NOT A GUARANTEE OF PAYMENT. ANY BALANCE REMAINING IS THE RESPONSIBILITY OF THE PATIENT OR GUARANTOR.

As form of payment we accept; MC, Visa, Debit Cards and Cash.

**** **Please Initial this form ; (_________)**