# Sunrise Valley Dental Associates, PLLC

## INSURANCE INFORMATION SHEET

Subscriber Name (employee w/insurance): _____
Subscriber Address: _____
_____
Subscriber's Home # (___) _____ Work #: (___) _____
Subscriber's SSN: _____
Subscriber's Date of Birth: _____

Employer: _____
Employer's Address: _____
_____
_____

Insurance Company: _____
Mailing Address: _____
_____
_____

Phone # for verification: (___) _____
Insurance ID# (if not SSN) _____

Group # _____

Patients Covered by this Plan:

| Name | Date of Birth |
|---|---|
| | |
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I agree to pay an estimated copayment at time of service as requested. I understand that all fees are my responsibility and that any amount not paid by my insurance company within 45 days (in excess of estimated copayment) will be paid promptly by me upon receipt of a billing statement.

I permit any information necessary to process insurance claims for the above-referenced patients to be released to the insurance company and their consultants.

Signature: _____ Date: _____
Name: _____