

POISET AND ASSOCIATES • PEDIATRIC DENTISTRY AND ORTHODONTICS

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INSURANCE INFORMATION

PATIENT'S NAME _____ DATE _____

PRIMARY

NAME OF INSURED _____

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____

SS # / ID # _____

NAME OF INSURANCE COMPANY

GROUP/PLAN # _____

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

PHONE – INSURANCE COMPANY _____

EMPLOYER NAME _____

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

SECONDARY

NAME OF INSURED _____

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____

SS # / ID # _____

NAME OF INSURANCE COMPANY

GROUP/PLAN # _____

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

PHONE – INSURANCE COMPANY _____

EMPLOYER NAME _____

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

I hereby instruct and authorize that _____ Insurance Company is to make a payment by check payable to Poiset and Associates, the professional or dental expense benefits allowable, and otherwise payable to me under my current insurance policy. This is a direct assignment of my benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

SIGNATURE

DATE