II. Dental Insurance Coverage Information

This Dental Insurance Coverage is for: Date of Birth:

A1. Primary Dental Insurance Coverage:

Primary Insurance Coverage - If taking a copy of an insurance coverage card is not possible, please complete the following:

Subscriber/Insured's Name: Insured's Birthdate:

Insured's SS/ID Number: Group/ID Number:

Patient is the Subscriber/Insured's: ☐ self ☐ spouse/partner ☐ child ☐ other:

Name of Insurance Company:

Insurance Company Address:

Insurance Company Phone Number(s):

Assignment of Benefits: " For dental services rendered, I authorize that my dental insurance company receive claims and issue payment to Belltown Dental/Christine Shigaki D.D.S., P.L.L.C."

Signature of Subscriber/Insured:

B1. Secondary Dental Insurance Coverage:

Secondary Insurance Coverage - If taking a copy of an insurance coverage card is not possible, please complete the following:

Subscriber/Insured's Name: Insured's Birthdate:

Insured's SS/ID Number: Group/ID Number:

Patient is the Subscriber/Insured's: ☐ self ☐ spouse/partner ☐ child ☐ other:

Name of Insurance Company:

Insurance Company Address:

Insurance Company Phone Number(s):

Assignment of Benefits: " For dental services rendered, I authorize that my dental insurance company receive claims and issue payment to Belltown Dental/Christine Shigaki D.D.S., P.L.L.C."

Signature of Subscriber/Insured: