Joyce A. Perih D.D.S., M.S.
ORTHODONTICS

DENTAL **INSURANCE INFORMATION**

Providing the following dental insurance information will assist us in the determination of your dental and orthodontic insurance benefit(s) that will be presented to you at the exam appointment. Without this information, our staff will not be able to accurately provide you with an estimated treatment fee at your first appointment.

Please return this form along with your health history prior to your scheduled exam appointment in the enclosed self-addressed stamped envelope.

Complete the following utilizing the information on your insurance card that provides your dental benefits. If patient is covered under two (2) insurances, please use the back of this form to provide the secondary coverage information.

PLEASE PRINT

_____ Date of Birth_____/_____/_____
PATIENT'S NAME

_____ **Date of Birth** _____/_____/_____
INSURED NAME

HOME ADDRESS OF INSURED _____

INSURED SOCIAL SECURITY # _____/_____/_____ HOME PHONE NUMBER _____

_____**PHONE NUMBER** _____
INSURANCE COMPANY

_____ _____
GROUP # ADDRESS CITY STATE ZIP CODE

INSURED EMPLOYER _____PHONE NUMBER_____

_____
EMPLOYER ADDRESS CITY STATE ZIP CODE

I hereby authorize release of any information relating to this claim.

_____ Date _____
Signature of Insured

1210 O'NEILL HIGHWAY DUNMORE, PA 18512
P 570.969.9650 ~ F 570.963.5888
info@perihsmile.com ~ www.perihsmile.com

SECONDARY COVERAGE
DENTAL INSURANCE INFORMATION

PLEASE PRINT

_____ **Date of Birth** _____/_____/_____
INSURED NAME

HOME ADDRESS OF INSURED _____

INSURED SOCIAL SECURITY # _____/_____/_____ HOME PHONE NUMBER _____

_____**PHONE NUMBER** _____
INSURANCE COMPANY

_____ _____
GROUP # ADDRESS CITY STATE ZIP CODE

INSURED EMPLOYER _____PHONE NUMBER_____

_____
EMPLOYER ADDRESS CITY STATE ZIP CODE

I hereby authorize release of any information relating to this claim.

_____ Date _____
Signature of Insured

1210 O'NEILL HIGHWAY DUNMORE, PA 18512
P 570.969.9650 ~ F 570.963.5888
info@perihsmile.com ~ www.perihsmile.com