INSURANCE INFORMATION
NuYu Dental

Insurance Holder's Name Sex Birthday Soc. Sec. #

Patient's Name Sex Birthday Soc. Sec. #

Primary Dental Carrier:

Insurance Company_____

Insurance Company Phone #_____

Insurance Holder's Employer _____

Any numbers that may be required (such as: Group #, Employee #, etc.)

_____

Secondary Dental Carrier (if applicable):

Insurance Company_____

Insurance Company Phone #_____

Insurance Holder's Employer _____

Any numbers that may be required (such as: Group #, Employee #, etc.)

_____

I authorize release of any information relating to my claim. I authorize payments directly to NuYu Dental. I understand that all fees not paid by insurance are my responsibility.

Signature_____Date _____

Witness_____

Note: If you have not already and if you have an insurance card, please give it to the receptionist so she can make a photocopy which will help in speeding your insurance claim.

The following information is important for the patient's maximum safety, comfort and optimum dental care. This information will be held in the utmost confidence by this office.