Insurance Verification

Name of Primary Insured Person:

Name: _____

Employer: _____

Social Security # or ID#: _____ Date of Birth: _____

Dental Insurance Information:

Insurance Company Name: _____Phone #_____

Insurance Mailing Address: _____

Insurance City/State/Zip Code: _____

Group or Policy #: _____ Payor ID#: _____

I Authorize release of any information relating to this claim and authorize payment of dental benefits otherwise payable to me directly to Houston Endodontic Specialists, Inc. I understand that if the insurance does not pay within 90 days for any reason, I am responsible for payment in full.

Signature (Responsible Party): _____ Date: _____