Associated Endodontists

Dr. Lisane Paquette Dr. Andrew Gaffen Dr. Helena Lim

CDAnet INSURANCE DATA INFORMATION FORM

Policy Holder Insurance Information

Name of policy holder .....

Date of birth .....

Name, Insurance Co. ..... Policy No. .....

Subscriber ID number .....

Place of employment .....

Are you claiming from more than one insurance company no yes
If yes, complete the following block

Other Policy Holder Insurance Information

Name of policy holder .....

Date of birth .....

Name, Insurance Co. ..... Policy No. .....

Subscriber ID number .....

Place of employment .....

Other than the policy holder(s) above, indicate patient's name and relationship to insurance policy holder by encircling the following...

Patient's name .....Relationship * **D S**
Patient's name .....Relationship * **D S**
Patient's name .....Relationship * **D S**

*** D = DEPENDENT S = SPOUSE**

CONSENT FOR RELEASE FORM

I authorize my insuring company plan administrator to release the information contained in this claim.
I authorize Associated Endodontists to communicate with my insurance company and my dentist via email.

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Signature of patient, parent or guardian