DR. REED C. FERRICK 3750 *Montgomery Drive, ... a Rosa, CA 95405 (707) 542-6772*

Fill out all lines. If you need help, ask for assistance. Please print.

Patient Name: ________________________ **Date:** ____________

If full time student, name of school: ________________________

PRIMARY CARRIER:

Birth date: ____________

Employee Name: ________________________ Social Security #: ____________

Mailing Address: ________________________ Phone #: ____________

City, State, Zip: ________________________

Employer Name (Company): ________________________ Phone #: ____________

Mailing Address: ________________________

City, State, Zip: ________________________

Insurance Company Name: ________________________ Phone #: ____________

Mailing Address: ________________________

City, State, Zip: ________________________

Group or Policy #: ________________________ Date insurance took effect: ____________

Union Local: ________________________

Patient Relationship to Employee: (circle one) **[I-Same] [Spouse] [Child] [Other]**

SECONDARY CARRIER:

Birth date: ____________

Employee Name: ________________________ Social Security #: ____________

Mailing Address: ________________________ Phone #: ____________

City, State, Zip: ________________________

Employer Name (Company) ________________________ Phone #: ____________

Mailing Address: ________________________

City, State, Zip: ________________________

Insurance Company Name: ________________________ Phone #: ____________

Mailing Address: ________________________

City, State, Zip: ________________________

Group or Policy #: ________________________ Date insurance took effect: ____________

Union Local: ________________________

Patient Relationship to Employee: (circle one) **[I-Same] [Spouse] [Child] [Other]**

I hereby authorizes the release of all information (including X-rays) relating to examination or treatment to health service plans and insurance companies; or to any peer review committee or state and local dental association, which may request it.

I hereby authorize payment directly to Dr. Reed C. Ferrick of the group insurance benefits otherwise payable to me, but not to exceed the actual charges for the covered services. I understand that I am financially responsible for any charges not covered by the group insurance benefits.

Patient Signature: ________________________ **Date:** ____________

FOR OFFICE USE ONLY: INSURANCE BENEFIT

Maximum : ________ **Deductible :** ________ **Waived on Prev.:** ☐ Yes ☐ No

P rev : ________ **Basic :** ________ **Maj :** ________ **Cal Yr:** ________

Prophy: ☐ Two or ____ /Yr **or** ☐ 6 Mnths or ☐ 12 Mth Per. **Endo/Perio:** ☐ Basic or ☐ Major

Posterior Composites Downgraded: ☐ Yes ☐ No **X-rays:** ____ (FMX) ____ (BWX)

Exclusions : ________ **Replacement Frequency::** ________ **Waiting Periods :** ________

Date insurance took effect : ________ **Group/Policy :** ________ **Sub Loc:** ________

INSURANCE INFORMATION FORM