Dear Patient with Dental Insurance
In order for us to help you maximize your insurance benefits, please supply us with the following insurance information.

Patient name_____ Social Security#_____

Patient
address_____

Policy Holder's
Name_____

Policy Holder's Social Security #_____Policy Holder's Date of Birth_____

Patient relationship to Policy Holder_____ Patient Date of Birth_____

Policy Holder's
Employer_____

Insurance Company
Name_____

Insurance Company Address_____

_____

Insurance Company Phone Number_____

Please fax, mail or email this form before your appointment with a copy of your insurance card to:

Fort Hill Family Dentistry
PO Box 1907
Clemson, SC

Phone: 864-722-9050
Fax: 864-722-9070

E-Mail info@forthilldentistry.com