Advanced Dentistry of Blue Ash
Insurance Information Release Form

Policy Holder's Information

❑ Male
❑ Female

Policy Holder's Name _____ Birthday ___/___/___ Social Security Number ___-___-___

❑ Male
❑ Female

Spouses Name _____ Birthday ___/___/___ Social Security Number ___-___-___

Dependent's Name (last name if different than yours)

❑ Male
❑ Female

Dependent _____ Birthday ___/___/___ Social Security Number ___-___-___

❑ Male
❑Female

Dependent _____ Birthday ___/___/___ Social Security Number ___-___-___

❑ Male
❑ Female

Dependent _____ Birthday ___/___/___ Social Security Number ___-___-___

❑ Male
❑Female

Dependent _____ Birthday ___/___/___ Social Security Number ___-___-___

Insurance Information

Employer _____ Address _____, City _____, Zip _____ Phone Number _____

Insurance Company _____ Address _____, City _____, Zip _____ Phone Number _____

ID Number _____ Group Number _____ Plan Number _____

Secondary Insurance Information

❑ Male
❑ Female

Policy Holder's Name _____ Birthday ___/___/___ Social Security Number ___-___-___

Employer _____ Address _____, City _____, Zip _____ Phone Number _____

Insurance Company _____ Address _____, City _____, Zip _____ Phone Number _____

ID Number _____ Group Number _____ Plan Number _____

Please Initial:
_____ I authorize release of any information relating to my claim.
_____ I authorize payment directly to [insert doctor or practice's name].
_____ I understand that all fees not paid by insurance are my responsibility.

Print Patient Name _____ Patient Signature _____ Date _____

Employee Signature _____

Note: 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.