** GP Mobile Denture Services Ltd. Dental Insurance Company Information Form**

Tel: **(587) 299-5857**

Fax: **(587) 299-5877**

Email: **inquiries@gpmobiledentures.ca**

|  |  |  |
| --- | --- | --- |
| Patient Name: |              |  |
|  | Last | First  |  |  |
|  |
| **Primary Insurance Company** |
| Company Name: |       | Policy Number: |       |
| Address:  |       | Group Number: |       |
|  |       | Class: |       |
| Subscriber: [ ]  Patient |      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last First | ID Number: |       |
| Subscriber Date of Birth:  |      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MM/DD/YYYY | Place of Employment: |       |
| Subscriber Phone:  |       | Coverage (if known) |    % |
| Additional Information: |       |
|  |  |
| **Secondary Insurance Company** |
|  |
| Company Name: |       | Policy Number: |       |
| Address:  |       | Group Number: |       |
|  |       | Class: |       |
| Subscriber: [ ]  Patient |      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last First | ID Number: |       |
| Subscriber Date of Birth:  |      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MM/DD/YYYY | Place of Employment: |       |
| Subscriber Phone:  |       | Coverage (if known) |    % |
| Additional Information: |       |
|  |  |
| **Additional Insurance Company** |
|  |
| Company Name: |       | Policy Number: |       |
| Address:  |       | Group Number: |       |
|  |       | Class: |       |
| Subscriber: [ ]  Patient |      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last First | ID Number: |       |
| Subscriber Date of Birth:  |      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MM/DD/YYYY | Place of Employment: |       |
| Subscriber Phone:  |       | Coverage (if known) |    % |
| Additional Information: |       |
|  |  |
|  |
| **Method of Payment for non-insured portion(s)**[ ]  Invoice Patient/Guardian [ ]  Credit Card on file and authorized [ ]  Financial Terms Agreement on file |
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