** 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 | | | | | | | |
|  | | | | | | | |
|  | | | | | | | |