Lindner DENTAL
ASSOCIATES, P.C.

Date:_____ Lindner Dental Account #:_____

Please ask what your estimated out-of-pocket expense will be at the time of each appointment. All incomplete dental insurance information forms will be returned and cannot be processed.

*Insurance Company's Name _____

Self Funded Policy? Y N ***Employer Funded Policy? Y N***
Name of Employer_____

*Claims address _____
*Customer Service Phone # _____
*Group #:_____ *ID# _____

Was this insurance policy purchased through the Marketplace? YES/NO

Does this information replace the information we have on file? YES / NO

Is this insurance company in addition to the insurance on file? YES / NO

*Subscriber Name _____

Subscriber SS# _____ Subscriber Date of Birth_____

*Names of patients covered by this insurance & their relationship to subscriber:

Name	*Relationship*			
_____	Self	Spouse	Child	Student
_____	Self	Spouse	Child	Student
_____	Self	Spouse	Child	Student
_____	Self	Spouse	Child	Student

Patient address:_____
Home phone_____ Work/Cell_____
Email Address_____

I acknowledge that the information provided is accurate and current. If for any reason dental treatment is not covered for myself and/or members on my dental policy by my insurance carrier, I understand the dental charges are my responsibility.

Signature_____ Date_____

*****PLEASE ATTACH COPY OF FRONT & BACK OF INSURANCE CARD*******lda**