G & M Family Dental P.C.
160 South Central Avenue
Elmsford, NY 10523
(914)-592-4416

PRIMARY INSURANCE

Person Responsible For Account: _____
Last Name First Name Middle Initial

Relation To Patient: _____ **Birthdate:** _____ **ID#/Soc. Sec. #:** _____

Address (If Different From Patients):_____

City: _____ **State:** _____ **Zip:** _____

Person Responsible Employed By: _____ **Occupation:** _____

Business Address: _____ **Business Phone: (____)**_____

Insurance Company: _____

Contract # _____ **Group #** _____ **Subscriber #** _____

Names Of Other Dependents Covered Under This Plan: _____

_____

ADDITIONAL INSURANCE

Is Patient Covered By Additional Insurance? ◯**Yes** ◯**No**

Subscriber Name: _____
Last Name First Name Middle Initial

Relation To Patient: _____ **Birthdate:** _____

Address (If Different From Patients): _____

City: _____ **State:** _____ **Zip:** _____

Subscriber Employed By: _____ **Business Phone: (____)**_____

Insurance Company: _____ **ID#/Soc. Sec. #:** _____

Contract # _____ **Group #**_____ **Subscriber #**_____

Names Of Other Dependents Covered Under This Plan: _____

_____

PLEASE COMPLETE THE ABOVE INFORMATION