Robert C. Elliott, D.D.S., P.C.

Insurance and Billing Information

Person Responsible for Payment

Name: Last___________________________ First____________________________ MI_______

Sex: _______ Age_______ Date of Birth _____/_____/_____SSN _______________________

Mailing Address____

Street Address____

City_________________________________ State_________________ Zip_________________

Home Phone_____________________________ Mobile Phone____________________________

Email____

Employer_____________________________________ Work Phone________________________

Dental Insurance Information

Do you have dental insurance? ____________Yes ____________No

Name of insurance company ____

Insurance company address ____

Insurance company phone number ____

Insured Name_________________________________ Insured SSN_______________________

Insured Date of Birth _____/_____/_____ Insured Employer____________________________

Group # ____________________________ Member #___________________________________

Relationship of patient to insured ____

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