



Dr. Brad Rondeau D.D.S.  
Phone: 810-225-8338/Fax: 810-225-8333

## INSURANCE INFORMATION

### Patient and Subscriber Information

Patient Name: \_\_\_\_\_ Patient Birthdate: \_\_\_\_\_  
Person responsible for account: \_\_\_\_\_  
Insured employed by: \_\_\_\_\_ Employer phone number: \_\_\_\_\_  
Employer address: \_\_\_\_\_

Please provide your insurance card and driver's license so that we can scan them for our records.

Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Subscriber's SSN#: \_\_\_\_\_ Subscriber's birthdate: \_\_\_\_\_

Is patient covered under additional insurance? (Circle one) YES NO

If yes, please provide information about secondary coverage:

Secondary Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Subscriber's SSN#: \_\_\_\_\_ Subscriber's birthdate: \_\_\_\_\_

Dr. Rondeau chooses to use only white composite material for restorations and does not use silver amalgam. Please be aware that should the insurance plan not fully cover composite restorations, the difference in fee is the patient's responsibility.

## AUTHORIZATION FOR BILLING OF INSURANCE

I authorize the release of any medical information required by my insurance carrier(s) to determine benefits on my behalf. This expressly includes information regarding diagnosis or treatment of any drug, alcohol, AIDS, AIDS-Related Complex, HIV infection or mental illness. I request payment of authorized benefits be made on my behalf to Dr. Brad Rondeau, D.D.S. for any services provided by him.

AUTHORIZED SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_