DENTAL CLAIM FORM: Bradley M. Stewart D.M.D.
6855 Crumpler Blvd. Suite 100, Olive Branch, MS 38654

PATIENT'S INFORMATION:

Patient's Name: _____
Last *First* *Middle*

Date of Birth: _____ Sex: ☐male ☐female

Relationship to subscriber/employee: ☐self ☐spouse ☐child ☐other

EMPLOYEE/SUBSCRIBER INFORMATION:

Employee's Name _____
Last *First* *Middle*

Social Security # _____ Insurance ID # _____

Date of birth: _____ Marital Status: ☐ married ☐ single ☐ other

Address: _____

City: _____, State _____

Phone #: _____

Employer's Name: _____ Group #_____

Insurance Name: _____

SECONDARY INFORMATION: ***Fill out this section if patient is covered by another plan***

Name of other subscriber: _____
Last *First* *Middle*

Social Security # _____ Insurance ID # _____

Date of birth: _____ Marital Status: ☐ married ☐ single ☐ other

Employer's Name: _____ Group # _____

Insurance Name: _____

(1) I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law. I authorize release of any information relating to this claim. (2) I herby authorize payment of the dental benefits otherwise payable to me directly to the above named dental entity.

_____ _____
Sign (Patient/Guardian) Date: