Matthew D. Holley, D.M.D., P.C.
Comprehensive Dental Care
Implant · Sedation · Cosmetic

<u>INSURANCE AND BILLING INFORMATION</u>

Primary Insurance Subscriber: ____

Date of Birth: _________________________ **SSN**: _________________________

Primary Insurance Co: ____

Employer: ___________________________**Group No**: ________________ **ID**: __________________________

Secondary Insurance Subscriber: ____

Date of Birth: _________________________ **SSN**: _________________________

Secondary Insurance Co: ____

Employer: ___________________________**Group No**: ________________ **ID**: __________________________

I certify that I (and/or my dependent(s)) have insured coverage with the above listed insurance company and assign directly to Dr. Matthew D. Holley, D.M.D., P.C. all insurance benefits, if any, otherwise payable to me for service. I authorize the use of my signature on all insurance submissions. The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment and determining insurance benefits payable for related

services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature: ____ **Date**: ____________________