

Premier Dental Care
220 Horizon Dr., Suite F
Henderson, NV 89015

Alex Y. Song, D.D.S.

CHART # _____

Primary Insurance Information

Name of Insured Last _____ First _____ Initial _____

Soc. Sec. # _____ D.O.B _____ Relationship to patient _____

Address (if different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Employed by _____ Occupation _____

Employers Address _____ Work Phone#(____) _____

Insurance Company _____ Phone# _____

Address _____ City _____ State _____ Zip _____

Secondary Insurance Information

Name of Insured Last _____ First _____ Initial _____

Soc. Sec. # _____ D.O.B _____ Relationship to patient _____

Address (if different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Employed by _____ Occupation _____

Employers Address _____ Work Phone#(____) _____

Insurance Company _____ Phone# _____

Address _____ City _____ State _____ Zip _____

Assignment of benefits: I hereby authorize and request my insurance company to pay directly to Premier Dental Care the amount due on my claim for services rendered to my dependant or me. I further agree that should the amount be insufficient to cover the entire dental expense, I will be responsible for payment of the difference; and if the nature of the liability were such that it is not covered by the policy, I will be responsible to Premier Dental Care for payment of the entire bill.

Signed: _____ Date: _____