Diane Buyer, D.D.S. *Smiles for a Lifetime*

Patient Insurance Information Form

**** Please Present Your Insurance Card to the Receptionist ****

Date: ___________________

Insured's Last Name: ____

Insured's First Name: ____

Address: ___________________________________ City: _____________ State: ________

Zip: ________ Email Address: ____

Date of Birth: ___________________ Social Security Number: ______________________

Home Phone: ( ) ____________________ Cell Phone: ( ) _________________________

Employer: ______________________________ Work Phone: ( ) ____________________

Insured's Group/Plan I.D. Number: ____

Dental Insurance Company: ____

Dental Insurance Company Phone: ( ) ____

Address: ___________________________ City: ______________ State: _____ Zip: _______

Second Insurance: ☐ Y* ☐ N **if yes, please complete the following*

Insured's Last Name: ____

Insured's First Name: ____

Employer: ______________________________ Work Phone: ( ) ____________________

Insured's Group/Plan I.D. Number: ____

Insurance Company: ____

Insurance Company Phone: ( ) ____

Address: ___________________________ City: ______________ State: _____ Zip: _______

Authorization to Release Information: Dr. Diane M. Buyer and Associates are authorized to provide any insurance company(s) claim administrator(s) and consulting health care professionals, information concerning healthcare, advice, treatment, or supplies provided, I understand that I am responsible for all costs of dental treatment.

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Signature (*Patient or Authorized Person*) Date

Authorization to Pay Benefits Directly to Dentist: I hereby authorize payment(s) to Dr. Diane M. Buyer and Associates for the dental benefits otherwise payable to me.

____

Signature (*Insured Person*) Date

1060 East 86th Street, Suite 59, Indianapolis, Indiana 46240-1868
(317) 846-9444 ▪ (317) 846-9454 Fax
info@dianebuyerdds.com ▪ www.dianebuyerdds.com