



JOEL W. UMALI, D.D.S.
232 Cajon St. Suite C
Redlands, CA 92373

Dental Insurance Information

We are pleased to welcome you to our office. Please take a few minutes to completely fill out this form. If you have any questions we'll be glad to help you. The following information will be confidential.

1. Patient Information

Patient Name

Date of Birth

Social Security #

2. Subscriber Information

Your relationship to subscriber: Self Spouse Child

Subscriber Name

Subscriber's Date of Birth

Subscriber's SS #

Insurance Company

Group Number

I.D. #

Is patient covered by additional insurance? Yes No *If yes, please proceed to Section 3

3. Secondary Insurance Information

Your relationship to subscriber: Self Spouse Child

Subscriber Name

Subscriber's Date of Birth

Subscriber's SS #

Insurance Company

Group Number

I.D. #

4. Assignment & Release

I certify that I and/or my dependent(s) have insurance coverage with _____ (insurance company) and assign directly to Dr. Joel Umali, all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dentist 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 for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Patient Name (Please Print)

Patient Signature

Date

Guardian or Responsible Party (Please Print)

Guardian or Responsible Party Signature

Date