

Dental Insurance

DR. DAVID V. BRIDGER INC.

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IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE:

Insurance Company: _____

Policy or Group Number: _____ Name of POLICY HOLDER: _____

SIN of POLICY HOLDER: _____ Date of Birth of POLICY HOLDER: _____

Certificate Number: _____ Division Number: _____ Dependent Number: _____

Percentage Coverage: Basic: _____ Major: _____ Ortho: _____

Annual Limit: _____ Annual Deductible: _____

Name of Employer: _____

Must the Dental Claim go through the Employer? _____

If so, Address of Employer: _____

Are you covered by a second dental insurance company? (Dual Coverage) Yes No

IF YOU HAVE DUAL COVERAGE, PLEASE COMPLETE:

Insurance Company: _____

Policy or Group Number: _____ Name of POLICY HOLDER: _____

SIN of POLICY HOLDER: _____ Date of Birth of POLICY HOLDER: _____

Certificate Number: _____ Division Number: _____

Percentage Coverage: Basic: _____ Major: _____ Ortho: _____

Annual Limit: _____ Annual Deductible: _____

Name of Employer: _____

Must the Dental Claim go through the Employer? _____

If so, Address of Employer: _____

INSURANCE

Dr. David V. Bridger Inc. complies with the 2004 Personal Information Protection Act (PIPA)

On your behalf, our office will correspond directly with your insurance company for any treatment for which written approval is on file. The patient is responsible for all fees not covered by insurance, and for any claims not accepted by insurance.

Please be advised that your records will be forwarded to your insurance company if required for pre-determination of benefits.

I hereby assign my benefits, payable from claims submitted electronically to Dr. David V. Bridger and authorize payment directly to him.

SIGNATURE OF SUBSCRIBER

DATE