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SUBMIT

Cloverdale Dental Group

Family & Cosmetic Dentistry

250 The East Mall, Suite 211

Etobicoke, ON M9B 3Y8

416.236.2304

PATIENT INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE CARRIER:

Insured's Name _____ SI# _____ Date of Birth_____

Insured's Employer_____ Employer's Address & Phone #_____

Insurance Carrier_____Group#_____Phone#_____

Insurance Carrier's Address_____

SECONDARY DENTAL INSURANCE CARRIER:

Insured's Name_____ SI# _____Date of Birth_____

Insured's Employer_____ Employer's Address & Phone #_____

Insurance Carrier_____ Group#_____ Phone#_____

Insurance Carrier's Address_____

AUTHORIZATION TO RELEASE MEDICAL/DENTAL INFORMATION:

I authorize the release of any medical/dental information necessary to process my insurance claim(s). I also certify that all insurance information given to **Cloverdale Dental Group** is correct and complete. A photocopy of my signature shall be valid as original.

Patient's Signature_____

Insured's Signature_____