KEITH W. STRAUSBAUGH DMD, PA
FAMILY & COSMETIC DENTISTRY

1525 CLEVELAND ST.
GREENVILLE, SC 29607
864-233-1905

Insurance Information

Name of Insured:_____Date of Birth:_____

Address:_____City/State/Zip:_____

Home phone:_____Work phone:_____SS#_____

Employed by:_____

Address:_____City/State/Zip:_____

Insurance Contact person or department:_____

Your relationship to the insured:_____

If patient is a minor, name and address of responsible party for payment:_____

_____Relationship:_____

Primary Insurance Company Name:_____

Address:_____City/State/Zip:_____

Phone #:_____**Group#** :_____**Policy#** :_____

Do you have secondary dental insurance coverage? Yes____No___If so, with whom?_____

_____

Coverage

Preventive_____ Cal. Year_____
Basic_____ Deductable_____
Major_____ Maximum_____
Ortho_____ Other_____

Acknowledgement_____

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I herby certify that the above information is correct. It is the patient's responsibility to file their own secondary dental insurance coverage. I understand that insurance may not cover all costs of treatment and I agree to pay my balance, 1% interest/month, and/or all costs of collection insured by KWSDMD. A $25.00 fee is charged for appointments canceled or broken without 24 hours advance notice.

Signature:_____**Date:**_____