Robert D. Elliott, DMD, MS **Cary Pediatric Dentistry** Julie R. Molina, DDS, MS
540 New Waverly Place • Suite 300 • Cary, NC 27518 • Telephone: (919) 852-1322 • FAX: (919) 852-1230

Patient Insurance Information

Our office is considered out of network for all insurance companies. Therefore, we request payment on the day of the appointment in full. We in turn will give you (the parent) a general claim form, with an itemized statement attached, to send into their insurance company for reimbursement. In order to complete this general claim form we will need to import your insurance information or any insurance changes into our computer system. Please fill out your insurance information below.

Primary Insurance

Insurance Company/plan name:______________________________

Insurance Company Address:______________________________
(P.O Box/Street #) (City) (State) (Zip Code)

Insurance phone #: ____________________

Policyholder/Subscriber Information

Policyholder's Name:______________________________
(Last) (First) (Middle Initial)

Policyholder Date of Birth:____________________ **Gender:** ☐ M ☐ F
(MM/DD/CCYY)

Policyholder/Subscriber ID: (SSN or ID#):____________________ **EDI #:**________________

Plan/Group Number:____________________ **Employer Name:**____________________

Scheduled Patient(s) Information

Patient Name:______________________________
(Last) (First) (Middle Initial)

Patient Name:______________________________
(Last) (First) (Middle Initial)

Patient Name:______________________________
(Last) (First) (Middle Initial)

Secondary Insurance (If not applicable leave blank)

Insurance Company/plan name:______________________________

Insurance Company Address:______________________________
(P.O Box/Street #) (City) (State) (Zip Code)

Insurance phone #:____________________

Policyholder/Subscriber Information

Policyholder's Name:______________________________
(Last) (First) (Middle Initial)

Policyholder Date of Birth:____________________ **Gender:** ☐M ☐F
(MM/DD/CCYY)

EDI #:________________

Policyholder/Subscriber ID: (SSN or ID#):____________________

Plan/Group Number:____________________ **Employer Name:**____________________