Pettyjohn Family Dentistry
66 West Springer Drive, Suite 304
Highlands Ranch, CO 80129
303-791-9141

Patient Name: _____

In order to facilitate your dental insurance processing, please provide the following information so we may submit your dental claims properly.

Your insurance carrier: _____

Claim mailing address: P.O. Box _____ OR
Street _____
City _____
State _____ Zip Code _____

Insurance carrier phone number: _____
(There is usually a member services phone number listed on your insurance card.)

Policy holder's employer: _____

Group name: _____

Group number: _____

Full name of policy holder: _____

Policy holder's social security number: _____

Policy holder's date of birth: _____

Patient's relationship to policy holder: _____

Signature of patient/parent/guardian: _____
(For release of information relating to any insurance claims AND allowing benefits payable to this office.)

THANK YOU