Philip B. Sallberg, DDS P.A.
308 Center Street West
Roseau, MN 56751
218-463-1070

Patient name_____
Insurance holder's name_____
Coverage: Single_____ Family_____
Patient status: Single____ Married____
Sex: Male___ Female___
Relationship to insured: Self__ Spouse__ Child__ Other__
If child, is he/she a student: full-time____ or part-time____
Patient's date of birth_____ Social Security number_____
Insurance holder's date of birth_____Social security number_____

Name of insurance company: _____
_____
_____

Insurance telephone number: _____
Insurance group number: _____
Employer of insurance holder: _____
Employer's address _____
Employer's phone number: _____

I authorize release of any information relating to this claim. I understand that I am responsible for all cost of dental treatment.

Signature_____Date_____

I hereby authorize payment directly to the above named dentist of the group insurance benefits otherwise payable to me.

Signature_____Date_____