STACY R. KANDA, D.D.S.
2335 SW 320TH ST., ● FEDERAL WAY, WA 98003 ● (253) 661-2222

Fill Out Completely and Sign

INSURANCE VERIFICATION

Date__________________

PATIENT: ____________________________________ BIRTHDAY_______________________

PRIMARY INSURANCE INFORMATION:

Name of Insured: ______________________________ Relationship to Patient_________________________

Birthday: _________________________SS#/SIN_____________________________________

Name of Employer_______________________________Date Employed________________

Insurance Company_____________________________Group #_______________________

Policy #/ ID#____________________ Insurance Co Phone #_________________________

WHEN BILLED TO INSURANCE I AUTHORIZE PAYMENT OF DENTAL BENEFITS TO DR. KANDA ON COVERED SERVICES.

Signed____ Date_________________________
Primary

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes____ No____

IF YES COMPLETE THE FOLLOWING: SECONDARY INSURANCE

Name of Insured: ______________________________ Relationship to Patient_________________________

Birthday______________________________SS#/SIN________________________________

Name of Employer____________________________Date Employed__________________

Insurance Company___________________________ Group #_______________________

Policy #/ID#_________________________ Insurance Co Phone #___________________

WHEN BILLED TO INSURANCE I AUTHORIZE PAYMENT OF DENTAL BENEFITS TO DR. KANDA ON COVERED SERVICES.

Signed____Date______________________
Secondary