Hudson Highlands Dentistry LLC
John T. Lynch, DMD

INSURANCE INFORMATION UPDATE

*required field

*Date ________

*Patient Name ________________________ ____________________ ____ *Date of Birth ______________
Last First Initial

If Child: Parent's Name ____

Please indicate any changes in your insurance and list who the new coverage affects below:

Dental Insurance 1st Coverage

Employee Name ________________________ Date of Birth ______
Employer Name ______________________________ Yrs. ______
Name of Insurance Co. ____________________________________
Address ____
City __________________________ State ____ Zip________
Telephone ____
Program or policy # ____________________________________
Social Security No______________________________________
Union Local or Group ___________________________________

Dental Insurance 2nd Coverage

Employee Name ________________________ Date of Birth ______
Employer Name ______________________________ Yrs. ______
Name of Insurance Co. ____________________________________
Address ____
City __________________________ State ____ Zip________
Telephone ____
Program or policy # ____________________________________
Social Security No. _____________________________________
Union Local or Group ___________________________________

Additional Information:

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