Thomas C. Lee, DDS, MS

INSURANCE SUBSCRIBER AUTHORIZATION FORM

Please provide following information for us to properly bill your insurance for you. Attach a copy of insurance card if available.

Patient Name: _____*Patient DOB:*_____

Subscriber Name: _____

Subscriber ID # or SSN: _____

Subscriber Date of Birth: _____

Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Phone #: _____

Group #: _____

Your relation to patient: _____

Please sign below giving us authorization to bill your insurance:

Subscriber Signature_____ *Date*: _____

If there is dual insurance please provide with additional information.

Thank you

Thousand Oaks
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