Insurance Information

PRIMARY COVERAGE

Employee Name _____ Date of Birth _____

Home Address _____

Social Security Number _____ Phone _____

Employer Name _____ Employer Phone _____

Employer Address _____

Does Your Company's Insurance Plan Allow You To Choose Your Own Dentist? _____

Insurance Company _____ Ins. Phone _____

Insurance Co. Address _____ Policy Number _____

Names of Any Minor Children Covered By This Policy:

_____

SECONDARY COVERAGE

Employee Name _____ Date of Birth _____

Home Address _____

Social Security Number _____ Phone _____

Employer Name _____ Employer Phone _____

Employer Address _____

Does Your Company's Insurance Plan Allow You To Choose Your Own Dentist? _____

Insurance Company _____ Ins. Phone _____

Insurance Co. Address _____ Policy Number _____

Names of Any Minor Children Covered By This Policy:

_____

INSURANCE RELEASE & FINANCIAL RESPONSIBILITY

I hereby authorize the release of any information, including but not limited to the records of any examinations, treatment and diagnosis to my insurance company or companies. This release is for the purpose of facilitation payment of my insurance benefits directly to our office for dental treatment.

Our office will assist with insurance billing, however treatment is not rendered on the assumption that fees will be paid by insurance. All dental treatment fees are the direct responsibility of the patient or parent. There will be a 1% monthly service charge (12% annually) added to any balance over 30 days. Collection referral and clerical service fees are added after 60 days; our NSF check and clerical service fees are each $45.00.

I understand that I am responsible for an accurate medical history and that all medical information is important in arriving at a diagnosis and treatment plan. I understand it is imperative to report any changes in my health or medication to my dentist.

PATIENT/PARENT SIGNATURE _____ DATE _____