

Dental Insurance

Primary Carrier

Insurance co. name _____ Insurance co. phone _____
 Address (Street, City, State, ZIP) _____
 Group no. (Plan or Policy no.) _____ Insured's I.D. no. _____
 Insured's name _____ Relationship to patient _____
 Date of birth _____ Insured's social security no. _____
 Insured's employer name _____ Is insured a patient in our practice? Yes No

Secondary Carrier

Insurance co. name _____ Insurance co. phone _____
 Address (Street, City, State, ZIP) _____
 Group no. (Plan or Policy no.) _____ Insured's I.D. no. _____
 Insured's name _____ Relationship to patient _____
 Date of birth _____ Insured's social security no. _____
 Insured's employer name _____ Is insured a patient in our practice? Yes No

Person Financially Responsible for Account

Name _____ Relationship to patient _____
 Social security no. _____ Phone () - _____
 Driver's license no. _____ Date of birth _____
 Address (Street, City, State, ZIP) _____
 Employer _____ Work phone () - _____
 Preferred payment method: Cash Credit Card Check
 Visa/MC/AMEX no. _____ Exp. date _____
 If patient is a minor, name of parent or legal guardian and relationship _____
 Is this parent or legal guardian currently a patient in our office? Yes No

Payment is due in full at the time of treatment

(Unless prior arrangements have been approved)

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency that may release such information to you. I will notify the dentist of any changes in my health or medication.

Signature _____ Date _____

Person to contact in case of emergency

Name _____ Relationship _____
 City _____ State _____ Cell phone _____
 Home phone _____ Work phone _____

OFFICE USE ONLY

I VERBALLY REVIEWED THE MEDICAL / DENTAL INFORMATION ABOVE WITH THE PATIENT NAMED HEREIN.

Date _____ Initials _____