PATIENT DENTAL INSURANCE INFORMATION

Insurance policies are a contract between you, the subscriber and the insurance company. The first appointment is on a cash basis, or until we have ascertained your eligibility. All payments made will go toward your deductible or percentage of treatment. Each patient is responsible for the total amount of the fee. As a courtesy, however, we will bill your insurance company. **If your insurance carrier does not remit payment within 30 days, the balance will be due in full from you.** Since we are not a party to your agreement with your insurance carrier, it is your responsibility to contact the insurance company with any questions regarding any payments from them. If any payment is subsequently made by your insurance in excess of the balance we estimated, we will refund you the credit amount.

INSURED – Primary Policy Card Holder

Name: _____ Birthdate: _____/ _____/ _____

Address: _____ Soc. Sec. No.: _____

City, State: _____ Carrier Name: _____

Employer: _____ Group/Contract No.: _____

SPOUSE

Name: _____ Birthdate: _____/ _____/ _____

Address: _____ Soc. Sec. No.: _____

City, State: _____ Carrier Name: _____

Employer: _____ Group/Contract No.: _____

COORDINATION OF BENEFITS INFORMATION: If a patient is eligible for coverage under two or more dental care programs, a claim must be filed with each carrier. To determine the order of benefit payment, the plan covering the patient as the employee has the primary responsibility for payment before the plan covering the patient as a dependent. If patient is a dependent child, the plan covering the patient as a dependent of the father has primary responsibility for payment before the plan covering the child as a dependent of the mother.

DEPENDENT CHILDREN (To age 19), or (23 if full time student)

Name _____ Birthdate: _____/ _____/ _____

Full Time College Student: School Name: _____ City/State:_____

Name _____ Birthdate: _____/ _____/ _____

Full Time College Student: School Name: _____ City/State:_____

Name _____ Birthdate: _____/ _____/ _____

Full Time College Student: School Name: _____ City/State:_____

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

_____ _____

Printed Name of Primary Policy Card Holder Date

_____ _____

Authorized Signature of Primary Policy Card Holder Date