INSURANCE INFORMATION

Name of Patient: _____ Date: _____

Do you have insurance coverage? [] yes [] No If No, go directly to section 3

Do you have dual insurance? [] yes [] No if No, complete section 1 & 3 only

SECTION 1: Primary Insurance Coverage

Name of Subscriber: _____ Relationship to patient: _____

Birthdate: _____ Social Security Number: _____ Occupation: _____

Name of Employer: _____ Number of Years Employed: _____

Employer Address & Phone: _____

Insurance Company: _____ Group Number: _____

SECTION 2: Secondary Insurance Coverage

Name of Subscriber: _____ Relationship to patient: _____

Birthdate: _____ Social Security Number: _____ Occupation: _____

Name of Employer: _____ Number of Years Employed: _____

Employer Address & Phone: _____

Insurance Company: _____ Group Number: _____

SECTION 3: Our Financial Policy

Payment is due as services are rendered unless other arrangements are made. As a courtesy to our non-insured patients, we will accept personal checks and major credit cards.

As a courtesy to our patients covered by dental insurance plans, we will submit the necessary forms to your insurance company. However, the patient is still responsible for payment of deductible amounts, co-payments, and services not covered by your insurance.

I understand that where appropriate, credit bureau reports may be obtained. In cases where a child is under 18 and separation or divorce is involved, the parent accompanying the child is responsible for payment of services.

Signature: _____ Date: _____

Patient Information Initials/Updates: _____ _____ _____ _____

_____ _____ _____ _____