Dental Insurance Information

Subscriber's Name ____

Birth date ________________________ SS# / ID#____________________________________

Relationship to Patient ____

Insurance Co. ______________________________Group # ___________________________

Name of Employer____

Is Patient covered by additional insurance? _____ Yes _____ No

Subscriber's Name ____

Birth date ________________________ SS# / ID# ___________________________________

Relationship to Patient ____

Insurance Co. _______________________________Group # __________________________

Name of Employer____

ASSIGNMENT AND RELEASE

If you have dental insurance, we want you to receive the full benefit of it. Our office team can assist you in completing your insurance forms and verifying the coverage that your particular program provides. We accept assignment of your insurance payment; another service to you. This means that you are responsible for your deductible and the portion the insurance does not cover. Remember, that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and us.

DATE ____

Print name of Patient, Parent or Guardian____

Signature of Patient, Parent, or Guardian____

Relationship to Patient ____