INSURANCE INFORMATION

Name of Insured: _____ is insured a patient? _____

Insured's Birth Date: _____ ID#: _____ SS# _____

Group# _____ Insured's Employer: _____

Patient's relationship to insured ___ Self ___ Spouse ___ Child ___ Other _____

Please read and sign to have our office file your insurance. I authorize the release of information and understand that I am responsible for all costs of dental treatment. I hereby authorize payment to the below named dentist.

_____ *Date:: _____*
Signature of patient, parent or guardian

CONSENT FOR SERVICE

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental service. This office will prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Insurance companies have a wide variety of rules and exclusions that the office may not be aware of. The office staff will estimate insurance coverage to the best of their ability but the patient agrees that this is an estimate only, not a guarantee of coverage.

_____ *Date:: _____ Relationship to patient: _____*
Signature of patient, parent or guardian

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