

## INSURANCE INFORMATION

Person Responsible for payment

Name \_\_\_\_\_ SSN \_\_\_\_\_ Marital Status \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Male/Female \_\_\_\_\_ Married Single Child \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext \_\_\_\_\_  
Employer Name \_\_\_\_\_  
Employer Address \_\_\_\_\_

### PRIMARY INSURANCE

Subscribers Name \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Group Plan \_\_\_\_\_  
Group Number \_\_\_\_\_ Subscriber ID Number \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### SECONDARY INSURANCE

Subscribers Name \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Group Plan \_\_\_\_\_  
Group Number \_\_\_\_\_ Subscriber ID Number \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(signature required for us to submit your insurance claim by computer.)

I hereby authorize payment directly to the below named dentist of the dental benefits otherwise payable to me.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(signature required for us to accept assignment of benefits.)

**OFFICE FINANCIAL POLICY:** Payment is expected at the time of your appointment. As a courtesy to our patients we will accept assignment of benefits for the estimated insurance coverage. Your uncovered portion is due at the time of service and can be paid with cash, check, Visa, Mastercard, Discover, or American Express. When your insurance payment is received and covers less than the estimated amount, then we will bill you for the difference.