DENTAL INSURANCE INFORMATION:

DO YOU HAVE DENTAL INSURANCE? YES___ NO___ (if no, please sign below)

Insurance Company's Name:_____

Name of Insured:_____

Employer of Insured:_____

SS # of Insured: _____

Birth Date of Insured: _____

Relationship to Insured: _____

DO YOU HAVE DENTAL CO-INSURANCE? YES___ NO___ (if no, please sign below)

Insurance Company's Name:_____

Name of Insured:_____

Employer of Insured:_____

SS # of Insured: _____

Birth Date of Insured: _____

Relationship to Insured: _____

PLEASE ASSIST OUR OFFICE IN OUR ATTEMPT TO OBTAIN ANY BENEFITS DUE TO YOU UNDER YOUR DENTAL INSURANCE PLAN(S). PLEASE KEEP US UP TO DATE WITH THE MOST CURRENT INFORMATION YOU HAVE REGARDING ANY CHANGES TO THE FOLLOWING:

Your Home (billing) Address, Phone Numbers (home, work, cell), Allergies, Medications and Dental Insurance Plan Information.

We do our best to be your advocate. However, we can only be effective if the information given to us is accurate. We thank you for your prompt assistance.

Any services not covered (in part or in full), denied due to Detnal Insurance plan limitations or unpaid within 60 days are the financial responsibility of the undersigned.

Patient's/Parent's Signature_____ **Date**_____