BLACK HILLS Pediatric DENTISTRY

Where Bright Smiles Begin

DENTAL INSURANCE INFORMATION

Primary Insurance Co. _____ Ins. Co. Phone: _____
Primary person on Policy? _____ I.D. # _____
Date of Birth _____ Group # _____
Employer _____

Secondary Ins. Co. _____ Ins. Co. Phone: _____
Primary person on Policy? _____ I.D. # _____
Date of Birth _____ Group # _____
Employer _____

MEDICAL / DENTAL RELEASE STATEMENT

I give my consent for the dentists at Black Hills Pediatric Dentistry to do a complete and thorough examination on the patient previously named, including any diagnostic x-rays needed. To the best of my knowledge, the information that I have given is correct and I understand that it will be held in the strictest confidence. Furthermore, I understand that it is my responsibility to inform Black Hills Pediatric Dentistry of any future changes to my child's medical status. As the parent or legal guardian of the previously named patient, I do hereby grant Black Hills Pediatric Dentistry and its staff permission to perform any needed treatment(s). I also understand that all necessary treatment will be explained prior to commencement and that I am responsible for payment in full at the time of service, unless prior arrangements have been approved. *Initial* _____

REQUIREMENT FOR FILING INSURANCE CLAIMS. To expedite the filing of my dental insurance claims, I do hereby authorize the release of confidential information to my dental insurance agency and understand that I am personally responsible for any balance remaining after the insurance payment has been received. I am also fully responsible if my insurance policy fails to pay, for any reason, within thirty (30) days of treatment. I hereby authorize payment of insurance benefits directly to Black Hills Pediatric Dentistry or the dentist that performs treatment on my child. (*Please Note: Blue Cross/Blue Shield and Dakotacare are handled differently as they only send the benefit checks directly to the policyholder. Since these two insurance carriers do not allow assignment of benefits, we must use a different policy when assisting our patients who are covered by BC/BS and Dakotacare. Please read our Blue Cross/Blue Shield and Dakotacare letter.*) In the event of payment default for services previously rendered, I also agree to pay all reasonable collection and/or legal fees incurred in an attempt to collect on this amount.

Parent or Legal Guardian Signature _____ Date _____

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