DENTAL INSURANCE

PRIMARY CARRIER

Insurance Company: _____

Insurance Company Address: _____
(Street)

_____
(City) (State) (Zip)

Employee / Policy Holder: _____ Employer: _____

Birthdate: _____ Social Security No.: _____

Group/Policy #: _____ Union/Local #: _____

Effective Date: _____ Maximum Yearly Benefit: _____

Phone Number: _____ Deductible: _____

SECONDARY CARRIER

Insurance Company: _____

Insurance Company Address: _____
(Street)

_____
(City) (State) (Zip)

Employee / Policy Holder: _____ Employer: _____

Birthdate: _____ Social Security No.: _____

Group/Policy #: _____ Union/Local #: _____

Effective Date: _____ Maximum Yearly Benefit: _____

Phone Number: _____ Deductible: _____

IF THIRD CARRIER PLEASE NOTIFY

DO YOU HAVE MEDICARE INSURANCE? _____

I hereby authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or companies. This release is solely for the purpose of facilitating the billing and reimbursement, directly to the physician, of insurance benefits under which I am entitled.

I agree to be responsible for payments of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1½% finance charge (18%) may be added to my account.

Patient _____ Date _____

Parent/Responsible Party _____ Relationship to Patient _____