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Dental Insurance

Primary

Name of EMPLOYEE: _____
Last First MI

Birth Date: _____ SS#: _____

Policyholder's Address: _____
Street City State Zip Code

Policyholder's Phone: _____
Home Work Cell

Policyholder's Employer Name:_____ Marital Status:_____

Patient's relationship to policyholder: ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Insurance Plan Name:_____ ID # _____

Group #:_____ Phone: _____

Secondary (If Applicable)

Name of Policyholder/Employee:_____
Last First MI

Birth Date: _____ SS#: _____

Policyholder's Address: _____
Street City State Zip Code

Policyholder's Phone: _____
Home Work Cell

Policyholder's Employer Name:_____ Marital Status:_____

Patient's relationship to policyholder: ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Insurance Plan Name:_____ ID # _____

Group #:_____ Phone: _____

Consent for Services

The estimated fee quoted from your insurance is only an estimate based on claims received in their office at that time. Any remaining balance after insurance reimbursement to our office will be your responsibility and will be billed to you.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

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 services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

By signing with form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment, and agree to their content.

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