Patient Insurance Information

Does the patient have Dental Insurance? ☐ **Yes** ☐ **No**

Dental Insurance Information Must Be Completely Filled Out

Dental Insurance Name: _____

Claims Mailing Address (we cannot submit to your insurance without this information):

_____

_____

Dental Insurance Phone Number: _____

Dental Insurance ID: _____

Dental Insurance Group Number: _____

Is the patient the primary insurance holder? ☐ **Yes** ☐ **No**

If the answer to the last question was no, please fill out the following information for the primary holder of the dental insurance plan. Without this information we will not be able to submit to the insurance.

Name of Primary Insurance Holder: _____

Insurance Holders Date of Birth: _____

Social Security Number of Insurance Holder: _____

Please inform the front desk if you have a secondary dental insurance.

Medical Insurance Information

Name of Insured: _____

Relationship to patient: ☐ **Self** ☐ **Child** ☐ **Spouse** ☐ **Other**

Insurance Holders Date of Birth: _____

Insurance Plan Name: _____

Insurance ID Number: _____

Insurance Group Number: _____

I authorize my insurance company to pay the dentist all insurance benefits rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not my insurance pays. I understand that the fee estimate listed for any dental care on a treatment plan can only be extended for a 90 day period from the date of the initial examination.

Signature: _____ **Date:** _____

Patient Initials _____