Insurance Information

Instructions: Pleas be sure to complete all information preceded by an asterisk. Failure to give this information will only delay the submission of your claims to the insurance company and require further contact with you to obtain the needed information.

*Patient _____ Date_____
*Reason for new insurance information: New patient? ____ New job? _____
Whole company has changed insurance? _____ Other _____
*Policy holder's full name _____
*Policy holder's SS# _____Date of Birth _____
*Policy holder's insurance ID# _____
*Policy holder's employer _____
*Insurance company _____
Insurance co. mailing address:_____
_____
Group or Policy # _____
*Toll Free # _____

***List family members on policy**	**Date of Birth**	**Relationship**

Are any of these insured members covered by another dental insurance policy?_____
If we do not have the information on the other policy, please complete a separate form for that policy.

PLEASE READ: Once your plan has been verified we will submit claims to your insurance company for payment. New patients are required to pay for their first visit. Their claim will be submitted to be paid to them. Thereafter, payment is required at the time of service for patients to which the insurance company pays directly to them. Most plans only cover a portion of dental fees. You will be expected to pay any deductibles and unpaid portion at time of dental service.

Your signature serves as an assignment of benefits for any insurance coverage and as a release of information to your dental insurance company. I understand and agree that I will be responsible for any balance not covered by insurance, to be paid in full within 30 days. In the event that my account is turned over to a collection agency, I understand and agree I will be responsible for collection fees, attorney fees, court costs, etc. Any returned checks will be assessed a $25.00 fee.

I HAVE READ, UNDERSTAND AND AGREE TO THE OFFICE POLICES STATED ABOVE.
X_____Date _____