

Insurance Form

GENERAL INFORMATION

Patient Name Date of Birth

PRIMARY DENTAL INSURANCE

Policy Holder Self Other Policy Holder Name (if not patient)

Relationship to Patient Self Spouse Parent Legal Guardian Partner Other If other, please specify

Name of Employer Work Phone

Address of Employer City State Zip

Policy Holder Date of Birth Insurance Company

Insurance Group # Insurance Plan # Effective Date

SECONDARY DENTAL INSURANCE

Policy Holder Self Other Policy Holder Name (if not patient)

Relationship to Patient Self Spouse Parent Legal Guardian Partner Other If other, please specify

Name of Employer Work Phone

Address of Employer City State Zip

Policy Holder Date of Birth Insurance Company

Insurance Group # Insurance Plan # Effective Date

ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE INFORMATION

If I am entitled to benefits under Medicare, Medicaid, or any insurance policy or other health benefit plan (covering me or anyone legally responsible for me), in consideration of services provided to me, I assign, transfer and convey the benefits payable under such program, policy or plan for services rendered to me. I authorize payment of these benefits directly, with such benefits being applied to my bill. I understand and acknowledge that this assignment does not relieve me of financial responsibility for charges incurred by me or anyone on my behalf, and I hereby acknowledge responsibility for and agree to pay charges not paid under this assignment, including any coinsurance amounts, deductibles, Durable Medical Equipment, and any charges for service deemed to be non-covered, not pre-certified, or not pre-authorized by my insurance plan.

Initial

I give my consent for examination and treatment.

Initial

I authorize the release of information including the diagnosis, records, examination, treatment, radiology, and claims of information.

This information may be released to

Spouse Family Friend Other Treating Physician(s) Do Not Release my Medical Information

SIGNATURE

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

- I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful response and that my doctor and their staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of their staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Name of Patient/Legal Guardian

Signature of Patient/Legal Guardian

Date

All parties involved agree that this document may be signed electronically. The electronic signatures appearing on this document are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.