Dental Insurance Information

Name of subscriber _____ Birth date _____

List names of eligible family members on this policy, and relationship to subscriber

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # _____

Subscribers Group # _____ Subscribers ID # _____

Subscribers Employer _____

Secondary Insurance Information

Name of subscriber _____ Birth date _____

List names of eligible family members on this policy, and relationship to subscriber

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # _____

Subscribers Group # _____ Subscribers ID # _____

Subscribers Employer _____

Consent for Services for subscriber and all other eligible card members.

Payment is due in full at the time of treatment unless prior arrangements have been approved. This office accepts insurance, and I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. A service charge of 1 ½ percent per month (18% annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial agreement is made. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release any information, including the diagnosis and records of treatment or examination rendered, to my insurance company. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature of Patient _____ Date _____