Dental Insurance Form

Page 1

Policy Holders Primary Dental Insurance Information

We need your Dental Insurance information NOT your medical insurance information (they are different)

Are you covered under a dental insurance plan? *

○ Yes ○ No

Is the patient the dental insurance policy holder? *

○ Yes ○ No

Please attach a picture of your dental insurance card

(if available)

Make sure the photo is in focus and not blurry.

Front of Dental Insurance Card

Drop files to attach, Use Camera, or browse

Back of Dental Insurance Card

Drop files to attach, Use Camera, or browse

Policy Holders First Name *

Policy Holders Last Name *

Policy Holders Birth Date *

__/__/____

Policy Holders SSN# *

___-__-____

Policy Holders Employer *

Dental Insurance Carrier *

Dental Insurance phone number *

(___) ___-____

(located on back of your dental insurance card)

ID / Member # *

Group # *

Plan *

Page 2

Policy Holders Secondary Dental Insurance Information

We need your Dental Insurance information NOT your medical insurance information (they are different)

Are you covered by a secondary dental insurance plan? *

○ Yes ○ No

Is the patient the secondary dental insurance policy holder? *

○ Yes ○ No

Please attach a picture of your Secondary dental insurance card

(if available)

Make sure the photo is in focus and not blurry.

Front of Secondary Dental Insurance Card

Drop files to attach, Use Camera, or browse

Back of Secondary Dental Insurance Card

Drop files to attach, Use Camera, or browse

Policy Holders First Name *

Policy Holders Last Name *

Policy Holders Birth Date *

__/__/____

Policy Holders SSN# *

___-__-____

Policy Holders Employer *

Dental Insurance Carrier *

Dental Insurance phone number *

(___) ___-____

(located on back of your dental insurance card)

ID / Member # *

Group # *

Plan *

Page 3

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. 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 patients 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. 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, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. 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. I grant my permission to you or your assignee, to telephone me at home, cell, or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

Signature *

Date *

MM/dd/yyyy

Relationship to Patient *

○ Self ○ Parent/Guardian