Primary Dental Insurance

Co. Name:

_____

Address:

_____

_____

CITY STATE ZIP

Phone #: _____

Insured's Social Security#:

_____

Group # (Plan, Local, or Policy #):

_____

Insured's Name:

_____

Relation: _____

Date of Birth: ____/____/_____

Insured's Employer:

_____

Secondary Dental Insurance

Co. Name:

_____

Address:

_____

_____

CITY STATE ZIP

Phone #:_____

Insured's Social Security#:

_____

Group # (Plan, Local, or Policy #):

_____

Insured's Name:

_____

Relation: _____

Date of Birth: ____/____/_____

Insured's Employer:

_____

Payment Method:

____ Visa ____ MasterCard ____ Discover ____ Amex ____ Care Credit

_____ _____/_____

___ Credit Card – Enter card number # above (if accepted)

_____ I hereby authorize assignment of my insurance rights and benefits directly to the (Initials) provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if ordered at this office).

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.