

## **Dental Insurance Information**

Our office files insurance claims electronically. In order to ensure that your insurance claim is processed and not rejected; we ask that you fill out this form completely. Missing or incomplete information will result in *non-submission* of your claim and payment in full will be due on the day of service.

Insurance Company:			
Street	City	State	Zip Code
Insurance Company Phone Numbe	r( )		
Policy Holder:			
Name of Person Policy is under	Last Name	First Name	MI
Policy Holders Date of Birth	Social Security #	ID#	Group #
Policy Holder Employer's Name:		Phone: (	)
List all Family Members Covered by Name:	Date of Birth:		,
Name:			
Consent of Services: Patients who carry dental insurance under personally responsible for payment of all d collections from insurance companies and services on the assumption that our charge I have read the above condition	ental services. This office will help prowill credit such collections to the pations will be paid by an insurance compa	epare the patients insurance forms ent's account. However, this dental any.	or assist in making office cannot render
Thave read the above containen			
Signature of patient, parent or guardian	Date: R	Relationship to Patient:	