Dental Insurance

Primary

Name of EMPLOYEE: ______________________________
Last First MI

Birth Date: ________________ SS #: ____________________

Policyholder's Address: ______________________________
Street City State Zip Code

Policyholder's Phone: ______________________________
Home Work Cell

Policyholder's Employer Name: ________________________ Marital Status: ________________

Patient's relationship to policyholder: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________________

Insurance Plan Name : ______________________________

Group # : ____________________ Phone: ______________________________

Secondary (If Applicable)

Name of Policyholder/Employee: ______________________________
Last First MI

Birth Date: ________________ SS #: ____________________

Policyholder's Address: ______________________________
Street City State Zip Code

Policyholder's Phone: ______________________________
Home Work Cell

Policyholder's Employer Name: ________________________ Marital Status: ________________

Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________________

Insurance Plan Name : ______________________________

Group # : ____________________ Phone: ______________________________

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.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

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.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

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. 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.

By signing with form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

______________________________ Date: ____________ Relationship to Patient: ____________________
Signature of patient, parent or guardian