

Insurance Information

Name of Insured:
Last First MI

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name:

Insured Employer

Insured's Birthdate / ID# and SS# / Group#

Insurance Address and Phone Number

Do you have Secondary Dental Insurance?

Yes No

Name of person, office or other source referring you to our practice:

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate. I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

I understand that finance charges of 1.5% monthly or 18% annually will accrue on my account after 60 days. In the event I default on payments and collection action is initiated, I will take full responsibility for any charges for collection fees and/or attorney fees.