## Dental Insurance Information

The information we need below is for the person in your household that holds the insurance for you or your family. If the patient is a child this will be the parent or guardian that they are insured under.

Name of Insured_____ Relationship to Patient_____

Insured's Birthdate_____/_____/_____ Social Security #_____

Name of Employer or Self Insured_____

Dept & Shift _____ 1st 2nd 3rd HR Contact & Phone #_____

Name of Dental Insurance Company_____Payer ID#_____

Group #_____ID #_____

Claim Mailing Address_____

City_____ State_____ Zip Code_____

Have you been to any other Dental providers this year where you would have met your deductible? YES NO
Name of Dental Office _____Date of visit_____

Number of years at current employer_____ Are you covered by a secondary Dental plan? YES NO
Please provide Secondary info on lines below:

Name of Insured_____ Relationship to Patient_____
Insured's Birthdate_____/_____/_____ Social Security #_____
Name of Employer or Self Insured_____
Dept. & Shift _____ 1st 2nd 3rd HR Contact & Phone #_____
Name of Dental Insurance Company_____Payer ID#_____
Group #_____ID #_____
Claim Mailing Address_____
City_____ State_____ Zip Code_____

**We will gladly file your insurance claims to the company listed above. Please note that even though we call ahead for your benefits, we are only privileged to basic plan information. We will estimate your portion due at the time of visit using the information provided. You will be responsible for any co-payment or deductibles at the time of service. All amounts are approximate and you may be required to pay a remaining balance once your claim is received. We are not contracted by any insurance carriers. This means we are out of Network for all Insurance Carriers. We are a third party filing your claim. It is your responsibility to call if claims are delayed or denied. We electronically file claims daily for faster turnaround. If you do not get an EOB (Explanation of Benefits) within 2-3 weeks please call your carrier. After 4 weeks you will become responsible for full payment. Exceptions to this will be made on a case by case decision.**

**If you are being seen as an emergency 1st time patient, you will be required to pay for your visit in full and your insurance will make payment to you. Future appointments will be filed and only your co-payments/deductible will be due at time of service. I understand and will comply with the above information.**

**Signature that you understand the above policy**_____ **Date**_____