Billing Information

Name of Person Responsible for Account _____

If Responsible Party is Different From Patient:

Relationship to Patient _____

Address _____

Employer _____ Work Phone # _____

Dental Insurance Information

**Though we are not in network with dental insurance, we will submit all necessary correspondence to your dental insurance for your visits in our office. The insurance company will reimburse you directly. We find most dental insurance policies reimburse about one-half of the fees on average.
** For patients covered by more than one insurance company: When you have received payment from your primary insurance company, please forward the explanation of benefits that you receive from your primary insurance to us so we can then submit to your secondary insurance for your reimbursement.

Patient Name: _____

Patient Date of Birth: _____

Insurance Company Name and Address: _____

_____

_____

Phone # _____

Group # _____

Name of Policy Holder: _____

Employer: _____

Policy Holder ID # _____

Policy Holder Date of Birth _____

If patient is a minor, or attends college and is under parent's insurance:

Name of School He/She Attends _____

If claim is due to an accident:

Date of Accident _____

Brief Description of Accident _____

_____

I have read the policy regarding dental insurance and authorize the release of information to my insurance company relating to my insurance claims (applies only to patients that have dental insurance).
I understand that payment is due at the time treatment is rendered unless other arrangements have been made ahead of time. If I have dental insurance, I understand that they will reimburse me directly.

_____ _____

Signed (Patient, or parent if minor) Date