INSURANCE INFORMATION AND FINANCIAL POLICY

Patient's Name _____ **Date of Birth** _____

PRIMARY DENTAL INSURANCE COVERAGE

Insurance Company Name _____

Primary Insured's Name _____ **Date Of Birth** _____

Insured ID # or SS #_____ **Group #** _____

Insured's Employer _____

Insurance Co. Address _____

Insurance Co. Phone # _____

SECONDARY DENTAL INSURANCE COVERAGE **(If Any)**

Insurance Company Name _____

Primary Insured's Name _____ **Date Of Birth** _____

Insured's ID # or SS # _____ **Group #** _____

Insured's Employer _____

Insurance Co. Address _____

Insurance Co. Phone # _____

Payment for dental treatment is due at the time of service. As a courtesy to you, we will contact your insurance carrier to get a breakdown of benefits and file all dental claims. This will assist us in giving you the best possible estimate prior to your dental treatment. Please be aware that eligibility is not a guarantee of coverage as actual benefit payments are determined only when a claim is received and processed. You will be responsible for any balance on your account not paid by your dental insurance. If after insurance payment you have a credit balance, we will issue a refund check within 30 days from the date the payment is received.

Signature _____ **Date**_____

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