CONCERNING INSURANCE

As a courtesy, we will assign a staff person to assist you in attempting to verify your dental insurance coverage, determine the limitations of your policy, identify your maximum dental insurance benefits, and assist you with filing the necessary forms, so that you receive the benefits to which you are entitled.

There is no guarantee of insurance coverage or payment. You should be aware that your dental Insurance company does not guarantee payment, does not cover all procedures, and may not pay for any dental services provided. There is no guarantee we are in your dental network.

By signing below, you acknowledge that you have been fully informed in advance of receiving treatment that your insurance may deny payment for some or all of the dental services that may be recommended and provided by your dental care provider in this office.; you agree to be responsible for payment in full for charges, including "Covered Services" denied by your insurance.

INSURANCE INFORMATION

Patient Name _____ Relationship to Policy Holder

_____

Patient Date of Birth _____ Patient Social Security #

_____

Policy Holder Name _____ Policy Holder Date of Birth

_____

Policy Holder SSN or ID # _____ Employer

_____

Insurance Company

_____

Group #_____ ID #_____ Phone

#_____

Insurance Company Address

_____

City _____ State _____ Zip Code _____

☐ I authorize and request my insurance company to pay directly to the dentist, unless otherwise payable to me. I understand that there is no guarantee of insurance coverage or payment and that my dental insurance carrier may deny payment or pay less than the

actual bill for services. I agree to be responsible for payment for all services rendered on my behalf or my dependents. Initial_____

☐ I do not have dental insurance

_____ _____

Signature of Patient or Guardian Date