

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
	<input type="checkbox"/> YES <input type="checkbox"/> NO		
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER	SUBSCRIBER'S BIRTHDAY	SUBSCRIBER'S SSN / ID #
	<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT		
GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS	
SECONDARY COVERAGE	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
	<input type="checkbox"/> YES <input type="checkbox"/> NO		
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER	SUBSCRIBER'S BIRTHDAY	SUBSCRIBER'S SSN / ID #
	<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT		
GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS	

RELEASE INFORMATION

YOU MAY DISCUSS MY HEALTHCARE WITH

	YES	NO	OTHERS (PLEASE PRINT)
Health Care Providers			1.
Insurance Companies			2.

CONFIRMATIONS



DO YOU PREFER A CONFIRMATION CALL

No, it is unnecessary

Yes, it is a helpful reminder

ASSIGNMENT & RELEASE

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if he so determines. In consideration of the services rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy.

I consent to making of videotapes, photographs, and x-rays before, during, and after treatment, and to use the same by the doctor in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

SIGNATURE - PATIENT / GUARDIAN	DATE
WITNESS SIGNATURE	DATE