



Dental Insurance

We are delighted to file your primary dental insurance once coverage has been confirmed, however dental benefits are your financial responsibility. We will try to help you calculate your benefit in dollars, with any co-payment and deductible due at the time of service. Since this is an estimate, even with a pre-determination there can be no guarantee of what your insurance company will pay and you may be left with either a credit or a balance due. Credits may be applied to future treatment or a refund may be requested. If there is a balance due, you will receive a statement. If your insurance has not paid in 30 days, we will re-file your claim. After 60 days or if the claim is denied, the full balance becomes your responsibility. Our insurance coordinator will be glad to answer any questions about your dental coverage, including secondary insurance or medical benefits. _____ (please initial)

Policy Holder _____
Last Name First Name Middle Initial

Address _____

Phone _____ / _____ / _____
Home Work Cell

Policy Holder SS# _____ Policy Holder DOB _____

Policy Holder Place of Employment _____

Phone # _____ Benefits Director _____

Carrier Name & Address _____

Group Name _____ Group # _____

Does this plan cover family members? (Check One) YES NO

Family Members covered by dental insurance (list any additional members on back of sheet)

| First Name | Last Name | Sex | Relationship | DOB |
|------------|-----------|-----|--------------|-----|
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Assignment of Benefits/Release Information: I authorize payment of dental benefits to myself or the named provider for professional services rendered. I also authorize the release of any dental information to process this claim.

Signature _____ Date _____