

INSURANCE INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Social Security No. _____

Do you have dental insurance? Yes No

Name of Insurance Company _____ Phone# _____

Address of Insurance Company _____

Subscriber or Group #: _____

If you are not the subscriber:

Name of Subscriber _____ Date of Birth: _____

Subscriber Social Security No. _____

Subscriber place of employment: _____

Relationship to subscriber: _____

To avoid misunderstanding regarding dental insurance, we wish our patients to know that ALL PROFESSIONAL SERVICES RENDERED are CHARGED DIRECTLY TO THE PATIENT and that the PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENTS OF ALL FEES. We will prepare the necessary forms or reports to help you obtain your benefits from your insurance company. We do not render our services on the basis that insurance companies will pay our fees. We are an in-network provider for Delta Dental.

I understand the above statement and agree to the terms:

Signature of Patient