Dental Benefits Processing Information

Dental benefit coverage available? Y – N
Primary insurance company name: ____________________________
Policy subscriber's name: ___________________________________
Subscriber's date of birth (required): __________________
Subscriber's SSN (required): _________________________
Subscriber's policy ID number if different than SSN: _____________
Group name or program number: ______________________________
Employer or provider of insurance: ______________________________
Patient's relationship to subscriber: Self, Spouse, Child/dependent, Other

Is there a second dental insurance policy? Y – N
Secondary insurance company name: _________________________________
Secondary policy subscriber's name: __________________________________
Secondary policy subscriber's date of birth (required): ___________________
Secondary policy subscriber's SSN (required): _________________________
Secondary policy subscriber's ID number if different from SSN: _________
Secondary policy's group name/program number: ______________________
Employer or provider of secondary insurance: _________________________
Patient's relationship to subscriber: Self, Spouse, Child/dependent, Other

The information requested is the minimum required for accurate and efficient billing and processing of your insurance. We will not be able to bill insurance claims without this data.

AUTHORIZATION TO BILL/PROCESS INSURANCE

I hereby authorize my insurance benefits be paid directly to the dentist. I authorize the release of any information required by my insurance company to facilitate the processing of all claims. 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 understand that I am financially responsible for any balances after 60 (sixty) days whether or not my insurance has settled. Any fees associated with the collection of unpaid balances are the responsibility of the guarantor/subscriber. I certify that I have read or had read to me, if requested, the contents of this form and do realize the risks and limitations of receiving timely insurance reimbursement. I understand that with out the above requested information, insurance can not be processed.

Signature: __________________________________ Date: _________________