PRIMARY INSURANCE COVERAGE

SUBSCRIBER NAME AND ADDRESS: ____

RELATION TO PATIENT: ____________ SS#: ______-______-__________ DOB: _____/_____/_____

INSURANCE SUBSCRIBER # ____

EMPLOYER NAME AND ADDRESS: ____

INSURANCE COMPANY NAME AND ADDRESS: ____

GROUP #: ________ FAMILY YRLY DEDUCT: __________ INDIV YRLY DEDUCT: ______

PAYMENT POLICY

If you have dental insurance, we are pleased to assist you in receiving your benefits. As a courtesy, we submit your claim to the carrier when an insurance card and employment verification information is presented to the office. Any deductible, non-covered services and co-payments are due the day services are rendered.

APPOINTMENT POLICY

Your appointment times are reserved exclusively for you and therefore we require at least 48 hours notice if an appointment must be changed. This allows us to serve another patient who may be waiting for an appointment. A missed appointment fee of $50 will be charged on short notice cancellations.

RESPONSIBLE PARTY FOR PATIENT:

Name and Address: ____

Signature: ____

Please write any additional insurance information on the back of this form - Thank You!