Medical 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

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.

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Signature Date