Dental Insurance Benefits Information

Patient Name ____Date of Birth_______________

Insured's Name____

Date of Birth_____________________________SS#____

Employer and Address____

________________________________Employer Phone #_______________________________________

Insurance Company Name____

Claims Address____

Ins. Carrier's Phone Number____

ID# _________________________________Group #____

If you have dual or secondary coverage complete the following Information:

Which Insurance is primary? ____

Subscriber's Name____

Date of Birth_____________________________SS#____________________________________

Secondary Employer and Address____

__________________________Phone Number____

Insurance Company Name____

Claims Address____

Ins. Carrier's Phone Number____

ID# _____________________________________Group #______________________________

I give permission for Lakeland Dental Professionals PLLC to release any and all information in order to secure benefits. I authorize all insurance payments to be made to Lakeland Dental Professionals PLLC office. I understand that I am responsible for the total charges.

Lakeland Dental Professionals PLLC**office files primary and secondary insurance as a courtesy. If my insurance payment is not received within 60 days from the date of service, I will make payment to** Lakeland Dental Professionals PLLC **and I will be given an insurance claim form to seek reimbursement from my primary and/or secondary insurance carrier. I am responsible for knowing my benefit package information.**

All information given by Lakeland Dental Professionals PLLC staff is based on basic policy information and not individual policy plan provisions.

SIGNATURE OF GUARANTOR Date