Insurance Information

Initial: _____ **We accept assignment of benefits as an OUT OF NETWORK dentist. All benefits are based on estimates from your insurance company and are not exact amounts. By law, your insurance does not release exact amounts to dental practices. If you have any questions about the amounts your company benefits reimburse, please contact your Human Resources department.**

Name of Insured: _____ _____ _____
Last First MI

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Birth Date: _____ / _____ / _____ Social Security #: ____ - ___ - _____

Group #: _____

Insured's employer name: _____

Dental insurance company name: _____

**Please read and sign to have our office file your insurance*: I authorize the release of information and understand that I am responsible for all costs of dental treatment. I hereby authorize payment directly to the below-named dentist of the group insurance benefits otherwise payable to me.

_____ _____
Signature of patient, parent or guardian Date

Consent for Services

1. As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

2. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Insurance companies have a wide variety of rules and exclusions that the office may not be aware of. The office staff will estimate insurance coverage to the best of their ability, but the patient agrees that this is an estimate only, not a guarantee of coverage.

3. All patient accounts 60 days past due are considered delinquent, and those 90 days past due are subject to collections.

4. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

5. I agree to have any photos taken of me to be used for education and training. I have read the above conditions of treatment and payment and agree to their content.

_____ _____ _____
Signature of patient, parent or guardian Date Relationship to patient