Billing Information

I understand that payment is due at the time treatment is rendered.

If I have dental insurance, I understand that I will be reimbursed directly by my insurance company. I have read the policy regarding dental insurance below and authorize the release of information to my insurance company relating to my insurance claims.

Signed (Patient, or parent if minor) Date

If Responsible Party is Different From Patient:

Name of Person Responsible for Account _____

Relationship to Patient _____

Mailing Address _____

_____

Phone # _____ Email address: _____

Dental Insurance Information

**Though we are not in network with dental insurance, we will submit all necessary correspondence to your dental insurance for your visits in our office. The insurance company will reimburse you directly. We find most dental insurance policies reimburse about one-half of the fees on average.
** For patients covered by more than one insurance company: When you have received payment from your primary insurance company, please forward the explanation of benefits that you receive from your primary insurance to us so we can then submit to your secondary insurance for your reimbursement.

Patient Name: _____

Patient Date of Birth: _____

Insurance Company Name and Address: _____

_____

_____

Phone # _____

Group # _____

Employer: _____

Policy Holder ID # _____

If Policy Holder is Different From Patient:

Name of Policy Holder: _____

Policy Holder Date of Birth _____