Insurance Information:

Primary Plan	Secondary Plan
Insurance Co. Name:_____	_____
Group/policy number _____	_____
ID/Certificate number _____	_____
Coverage: Basic (%) _____	_____
Major (%) _____	_____
Orthodontic (%) _____	_____
Name of Policy Holder_____	_____
Birthdate of Policy Holder _____	_____
Employer of Policy Holder _____	_____

Please make note of the following; Your dental plan is a benefit that is offered through your workplace to yourself as an employment benefit. Benefits will range from plan to plan, depending on the package your employer has chosen. We are an assignment office, meaning we are more than happy to bill respective dental plans directly, if allowed, and process claims on your behalf. While we do our best to confirm eligibility on your behalf, we cannot assume responsibility for your coverage. Please be aware that any fees not paid by your dental plan within 90 days of submission will become your financial responsibility.

While many insurance companies will not discuss dental inquiries with us due to the Privacy Act, do we have your permission to speak to your insurance company on your behalf? Yes _____ No _____

Payment Policy

Payment is due upon completion of treatment. Please note that not all services may be covered by Insurance coverage. It is the patients' responsibility to cover the procedures that are not covered by their Insurance Plan.

_____	_____	_____
Date	Patient, Parent or Guardian Signature	Doctor's Initials