Insurance Information

*Please read and ask before your appointment if you have any questions regarding insurance.

Your insurance is a contract between you and the insurance provider, and you are responsible for it. As a condition of your treatment by this office, financial arrangements must be made in advance. We depend on reimbursement from our patients for any cost incurred In their care and the financial responsibility of each patient must be determined before treatment. Initial _____

Patients who carry dental insurance understand that all dental services furnished are charge directly to the patient and that they are personally responsible for payment of all dental services. We will help prepare your insurance forms, assist in making collections from insurance providers and will apply any such collections to your account. However, the office cannot render services on the assumption that our fee will be paid by an insurance provider. Insurance providers have a wide variety of rules and exclusions that may not be revealed to the office until payment is rendered. The office staff will **ESTIMATE** your insurance coverage to the best of their ability, but the patient agrees that This is an estimate only, not a guarantee of coverage. Initial _____

*We are **not "IN NETWORK"** however **we do accept your insurance and will file it for you.**

If your insurance changes at any time, it is your responsibility to let the office staff know **BEFORE YOUR APPOINTMENT,** otherwise you will be responsible for any services provided and insurance will reimburse you.
Initial _____

if you have dual or secondary insurance, the second part of the insurance is to be paid by the patient. Any reimbursement will go directly to the patient.
Initial _____

Therefore, in consideration of the services rendered to me, or at my request, by the Doctor, I agree to pay the reasonable value of sad service to the doctor or his assignee before the services are rendered. I grant my permission to you or your assignee, to telephone me at home or work to discuss matters related to this form.
Initial _____

*Signature_____ *Date_____

Policy Holders Name: _____

Policy Holders Date of Birth: _____

Policy Holders Social Security # (must have to file) _____

Policy Holders Home address: (including zip) _____

Policy Holders Employer: _____

Patients relationship to Policy Holder: _____

Dental Ins. Carrier Name: _____