# INSURANCE SUMMARY

**Patient Name:** First _____ Middle Initial _____ Last_____

**Date of Last Dental Visit:** _____

Have you had Dental Procedures performed at other facilities this year? This will help us to more accurately determine your remaining insurance benefit for the year.

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**PRIMARY INSURANCE CARRIER**

Policy Holder's Name:

First _____ Last_____ Date of Birth: _____

SS # _____ - ____ - _____ Relationship to Patient: _____ Phone #: ( ) _____

Employer: _____ Occupation: _____

Work Address: Address _____ City _____ State _____

Insurance Company: _____ Plan Name: _____

Group or Policy #: _____

Insurance Address: _____ City: _____ State: _____

**SECONDARY INSURANCE CARRIER**

Policy Holder's Name:

First _____ Last_____ Date of Birth: _____

SS # _____ - ____ - _____ Relationship to Patient: _____ Phone #: ( ) _____

Employer: _____ Occupation: _____

Work Address: Address _____ City _____ State _____

Insurance Company: _____ Plan Name: _____

Group or Policy #: _____

Insurance Address: _____ City: _____ State: _____

**CONSENT**

1. I authorize this office to communicate with my insurance providers in order to estimate my benefits and submit claims on my behalf.
2. I understand that there is usually an annual deductible fee that I must satisfy before my insurance provider will accept claims
3. I know that insurance providers pay only a percentage of each procedure and that there is an annual maximum of insurance pay out.
4. I accept that my Insurance Provider may deny my claims, and that I will be responsible to pay for the services rendered in this office.
5. I understand that my insurance will have exclusions to coverage. I also understand that there will be situations (ex. Use of benefits at another office) that may not be known by this office despite formulation of a treatment plan and that I will be responsible to pay for the balance of services rendered minus insurance payment despite a treatment plan.

**SIGNATURE OF RESPONSIBLE PARTY: _____ DATE: _____**

**RELATIONSHIP TO THE PATIENT: _____**