Dental Insurance

Primary Carrier

Insurance co. name:_____ Insurance co. phone:_____

Address:_____City:_____ State:_____Zip:_____

Group no. (Plan or Policy no.)_____ Insurance I.D. no. :_____

Insured's name:_____ Relationship to Patient:_____

Date of Birth:_____Insured's social security no. :_____ Employer Name:_____

Secondary Carrier

Insurance co. name:_____ Insurance co. phone:_____

Address:_____City:_____ State:_____Zip:_____

Group no. (Plan or Policy no.)_____ Insurance I.D. no. :_____

Insured's name:_____ Relationship to Patient:_____

Date of Birth:_____Insured's social security no. :_____ Employer Name:_____

Payment is due in full at the time of treatment

(Unless prior arrangements have been approved)

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency that may release such information to you. I will notify the dentist of any changes in my health or medication.

I agree to reimburse Pennyrile Family Dentistry the collection fees of any collection agency, which shall be based on a percentage at a maximum rate of 33.3 of the amount due at the time your account is placed with a collection agency, and all cost and expenses incurred for any collection efforts on your account, including reasonable attorney's fees incurred by the collection agency. This contract shall cover all medical/dental treatment and services until revoked by either party in writing.

Patient Signature:_____ Date:_____