Dentistry and Orthodontics for Children and Adults

Chestnut Dental Associates

DENTAL INFORMATION FORM

It is very important that all information regarding your dental insurance be accurate and up-to-date so that we may assist you in obtaining full insurance benefits.

DENTAL INSURANCE CARRIER: Primary_____ Secondary_____ Change_____

Subscriber's Name: ____
Address:____
City:______________________________ State__________ Zip:____________
Home Phone #:________________ **Business Phone #:**________________
Cell Phone #:________________ Spouses' Business Phone #:____________
Email address:____
Subscriber number:________________ **Subscriber DOB:**____________
SS#:________________________
Group #:____________________ **Effective Date:**______________

Employer Name:____________________________________
Address: ____________________________________
City: ______________________ State: ________ Zip: ________

DENTAL INSURANCE CARRIER: ____________________________________
Mailing Address:____
City:______________________________ State:_______ Zip:__________
Insurance Carrier Phone #:______________________________________

Patient Name(s):____
Date: ______________________________

My signature below shall serve as my informed consent to perform all recommended treatment for myself and/or dependants. It shall also serve as authorization to assign any dental benefits to my provider. I understand that estimated co-payments are estimates only, subject to policy maximums, limitations, and coordination of benefit rules in effect at the time of service. Any unpaid portion shall be my responsibility.

Please note: If your insurance company does not pay your claim within 60 days, you will become responsible for the charges.

Insurance companies have filing limits (the time between the date of service and the date the insurance company receives the claim). Claims presented beyond that time will not be paid by your insurance company and will become your responsibility.

Signature______________________________ Date__________ Update__________

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