DENTAL INFORMATION FORM

It is very important all information regarding your dental insurance is 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 #:_______________________
Business #:________________Cell #:_________________________
Spouse's #:_____________________Email address:_________________________________
Subscriber ID#:_____________________**Subscriber DOB:**__________________
SS#:____________________**Group#:**________________________ **Effective Date:**_______________

Employer Name:____

DENTAL INSURANCE PLAN NAME:______________________________________
Address:_________________________________City:_______________________MA:____Zip:______

Patient Name(s):____Date:_____________________

Secondary Insurance: Are Any Patients Covered Under Any Other Dental Plan? Yes_____ No_____

Subscriber's Name:____
Subscriber ID#: _____________________**Subscriber DOB**:________________
SS#:_____________________**Group#**:_____________________**Effective Date**:_________________

Employer Name:____

DENTAL INSURANCE PLAN NAME:____
Address:_______________________________City:_______________________MA:______Zip:_______
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 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:______________