Shah & Velilla DDS

Personal Care. Spectacular Smiles.

SANJIV SHAH, DDS • MORRIS VELILLA, DDS

□ Primary Dental Insurance □ Secondary Dental Insurance

Patients Name:	
Subscriber Name:	
Subscriber Address:	
Subscriber's Date of Birth:	
Employer :	
Ins. Company Name & Address:	
Family Members On Policy:	

ID # or SS#		Effective Date	
Group #		Relationship to Patient	

IMPORTANT DENTAL INSURANCE INFORMATION FOR OUR PATIENTS

Understanding your dental insurance coverage can be quite challenging; our goal is to assist you in maximizing your benefits.

We care for patients from many different companies. Each company pays an insurance premium for specific coverage, which fits the company budget. Each plan is slightly different in its covered services. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments.

Our courtesy service to you includes:

- Filing your insurance within 24 hours of your visit and requesting payment of your benefit to our office.
- Electronically filing your insurance for short turn around.
- Assisting you to the best of our ability to help maximize your benefits.
- Re-filing your insurance a second time within 60 days.
- Following the American Dental Association guidelines for coding procedures and filing insurance.

Our expectations of you as the owner of the policy:

- Payment of fees not covered by your insurance plan at the time the service is delivered.
- Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
- Realizing that dental insurance policies restrict payment for some services, use restricted fee schedules (called Usual and Customary Rates) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for insurance not our fees or recommended treatment.
- Taking responsibility for payment if the insurance does not pay our office within 90 days.
- Keeping our office informed of any changes in your insurance coverage or employment.

Thank you for your cooperation with your dental insurance coverage. Please sign the space below to authorize assignment of benefits and provide us with your insurance card to copy for our file.

_____ _____

Signature of Patient/Insured Date

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Patient information: (Confidential)

Name _____

Preferred Name_____ **E-mail** _____

Soc. Sec. #_____ **Birthdate** _____ **Home Phone**_____

Address _____

City _____**State** _____ **Zip** _____

Cell# _____ **Work #** _____

Check appropriate line: Minor ____ Single ____ Married ____ Separated ____ Divorced ____Widowed ____

Patient's or parent's employer _____ **Work number** _____

Business address _____ **City** _____ **State** _____ **Zip** _____

Spouse or parent name _____ **Employer** _____ **Work Phone** _____

Whom may we thank for referring you? _____

Responsible Party:

Name of person responsible for this account _____ **Relationship to patient** _____

Address _____Home phone _____Birthday _____

Employer _____Work phone _____SS#_____

Is this person currently a patient in our office? _____

Authorization: I have reviewed the information on this form and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status I will inform the dentist.

Signed:_____ Date:_____