Creative Dimensions in Dentistry's Insurance Information Sheet

Patient Name:_____ Acct # _____ Date: _____

To avoid misunderstandings regarding dental insurance, we would like our patients to know that all professional services rendered in this office are charged directly to the patient who is ultimately responsible for payment of all fees. If your dental insurance company fails to pay their portion or fails to pay the claim, you are responsible for payment of the balance due in full for any services rendered.

Our office provides a variety of flexible payment alternatives for your portion of the balance due, which make it affordable to receive dental care. Unless alternative financial arrangements are made in advance, payment is due when services are rendered.

As a courtesy we will submit your claims with the most current information you have provided us. You will receive monthly statements that reflect all current charges, payments and insurance submission information.

Primary Coverage

Subscriber: _____

Relationship to Patient: _____ Sex: _____

Address: _____

City, State, Zip: _____

Birth Date: _____

Social Security number: _____ _____ _____

Employer_____

Union Local _____

Ins. Carrier: _____

Group/Policy #:_____

Ins. Co. Phone number: _____

Secondary Coverage

Subscriber: _____

Relationship to Patient: _____ Sex: _____

Address: _____

City, State, Zip_____

Birth Date: _____

Social Security number: _____ _____ _____

Employer_____

Union Local _____

Ins. Carrier: _____

Group/Policy #:_____

Ins. Co. Phone number: _____

Authorization to Perform Dental Treatment

I hereby authorize the Doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. I also authorize the doctor to prescribe any and all forms of medications and perform any therapy that may be indicated and agreed upon.

I further authorize the release of any information, including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or consulting professionals. I understand that my responsibility of payment for dental services provided in this office for me or my dependants is mine, due payable at the time services are rendered.

Signature of patient or responsible party_____ Date_____