Dental Insurance Information

If you have dental insurance through an insurance company, please fill out the following information. Please disregard if you do not have dental insurance.

Primary Insurance Policy

Name of Insured: _____Patient: [ ] No [ ] Yes
Name of Insurance Company: _____
Insured's Birth Date: _____ ID:_____Group#:_____
Insured'sAddress:_____
City: _____Province:_____Postal Code: _____
Patient's relationship with insured: [ ] Self [ ] Spouse [ ] Child [ ] Other: _____
Dependant Number: [ ] 00 [ ] 01 [ ] 02-05 child/other

Secondary Insurance Policy

Name of Insured: _____Patient: [ ] No [ ] Yes
Name of InsuranceCompany:_____
Insured's Birth Date: _____ ID #:_____Group #:_____
Insured'sAddress:_____
City: _____Province:_____Postal Code: _____
Patient's relationship with insured: [ ] Self [ ] Spouse [ ] Child [ ] Other: _____
Dependant Number: [ ] 00 [ ] 01 [ ] 02-05 child/other

New Patient Insurance Registration Form

Understanding your insurance coverage can be a challenge. 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 with lower premium plans covering fewer services and lower fees for services. We encourage you to become familiar with your insurance including your amounts, eligibility, coverage, limits, etc.

Our courtesy service to you includes:

- Working with you to preauthorize for planned dental work with your insurance company as needed.
- Researching your dental insurance plan to advise you of estimated benefits that are available to you.
- Electronically filing your insurance benefits at the time of your visit and requesting reimbursement directly to you.

Our expectations of you as the owner of the policy:

- Payment of fees in full 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.
- Please bring all information relating to your Dental Insurance plan to us on your first visit.
- Keeping our office informed of any changes in your insurance coverage or employment.

_____ Date: _____

Signature or Patient/Insured