INSURANCE INFORMATION

If you have your dental insurance card, please give it to the receptionist.

Named Insured | Date of Birth | Relationship to patient

Employer | SS# / ID

Insurance Company | Address

Group # | Phone #

I understand that my insurance company will be billed for services provided for me today. I also understand that I am responsible for these charges and I agree to pay the entire amount due if any of the following occurs:

1- **Payment is not received within 60 days of billing**
2- **Payment is denied by the insurance company**
3- **A balance remains after insurance payment**

Signature of patient /insured /parent | Date