Davies
Pediatric Dentistry

INSURANCE INFORMATION

Primary Dental Insurance Company_____

Insured's Name_____

Insured's Birthdate____/____/__Insured's Social Sec. No._____

Insured's Employer_____

Insured's Group, Plan, Policy Number_____

Insurance Company Address_____

_____

Insured's Relationship to Patient:_____

Secondary Dental Insurance Company_____

Insured's Name_____

Insured's Birthdate___/___/___ Insured's Social Sec. No._____

Insured's Employer_____

Insured's Group, Plan, Policy Number_____

Insurance Company Address_____

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Insured's Relationship to Patient:_____

Our office will file a claim with your insurance company when possible. However, insurance policies and contracts differ considerably in the benefits offered. It is impossible for us to know the details involved in all the various policies. Dental insurance programs are designed to cover a *portion* of dental costs, and not the entire charges incurred. *The responsible party who attended that appointment will be responsible for all charges, regardless of insurance coverage.*

I authorize the release of information necessary to process my insurance claim, or to communicate with other doctors who may be involved in the patient's health care.

I authorize payment to the dentist of the insurance benefits otherwise payable to me. A copy of this signature is as valid as the original. I understand I am responsible for any amount not covered by insurance.

X_____Date_____