e Information

We will gladly file your insurance for you. We are only in network with Delta Dental Premiere. On out of network insurance companies you are responsible for any deductibles and copays at the time of service. We will estimate your cost to the best of our ability and file the rest with your insurance. Any remaining amount your insurance does not cover we will send you out a statement to you. If you have any questions please feel ask.

Please provide your dental insurance card to the front office.

Primary Dental Insurance

Name of ***Policy Holder***: _____

Address_____

Policy Holders Date of Birth: _____ ***Policy Holders*** Soc. Sec No. _____

Name of ***Employer***: _____

Name of Insurance Company:_____

Address of Ins. Company: _____

Name of Patient: _____

Relationship to patient: ◊Self ◊Spouse ◊Child ◊Other

Secondary Dental Insurance

Name of ***Policy Holder***: _____

Address_____

Policy Holders Date of Birth: _____ ***Policy Holders*** Social Security No. _____

Name of ***Employer***: _____

Name of Insurance Company:_____

Address of Ins. Company: _____

Name of Patient: _____

Relationship to patient: ◊Self ◊Spouse ◊Child ◊Other

I herby understand the statement above and understand anything my insurance does not cover I am solely responsible for.

Responsible Party: _____