# DENTAL INSURANCE

So that we can expedite your insurance reimbursement please fill out the information below.

Patient Name: _____ DOB:____/____/____
Last Name, First Name

Relationship to Insured: __Self __Spouse __Child __ Other

Insured/
Subscriber Name: _____ DOB:____/____/____
Last Name, First Name

Insured
Mailing Address: _____ City/State/Zip:_____

Insured Social Security#(Required): ____-___-____

Insured Identification #:_____

Company Name:_____ Insurance Plan Name:_____

Insurance Plan Group # or Policy # :_____

**Note for those patients who have dental insurance:**

It is our pleasure to assist you in maximizing your insurance benefits by submitting your dental claims for you. If your carrier utilizes today's technologies, then your claims will be submitted electronically via our computer system daily. This expedites your reimbursement.

**Your range of benefits depends solely on what your employer decided to purchase.** Some plans cover as little as 30% or as much as 100% of dental services
(less applicable deductibles, and plan maximums).

Some plans base the amount of benefit on a schedule of fees arbitrarily developed by insurance companies. For this reason, you may receive a lower percentage than the reimbursement level indicated in your dental plan.

Your insurance company is responsible to you, and not to our office. However, we will assist you in any way we can to maximize your available benefits.