INSURANCE INFORMATION & ASSIGNMENT OF INSURANCE

Date _____/_____/_____

Patient Name_____ Birth Date_____

PRIMARY INSURANCE

SS#_____ DL#_____

Name_____ Birthday_____/_____/_____
Relation to patient_____

Address (if different from patients)
Address_____ Apt. #_____
City_____ State_____ zip _____

Home ( )_____ Cell ( ) _____ Work ( )_____

Employer_____ Occupation_____
Address_____ Suite_____
City_____ State_____ Zip_____

Insurance Company_____ Phone #_____ ext_____
Insured ID Number_____ Group #_____

SECONDARY INSURANCE

SS#_____ DL#_____

Name_____ Birth Date_____/_____/_____
Relation to patient_____

Address (if different from patients)
Address_____ Apt. #_____
City_____ State_____ zip _____

Home ( )_____ Cell ( ) _____ Work ( )_____

Employer_____ Occupation_____

Address_____ Suite_____
City_____ State_____ Zip_____

Insurance Company_____ Phone #_____ ext_____
Inured ID Number_____ Group #_____

(PLEASE COMPLETE BACK SIDE)

Payment is due in full at the time of treatment unless prior arrangements have been approved. If this office accepts insurance, I understand that I am responsible for payment of services rendered, I am responsible for paying any co-payments and deductibles that my insurance does not cover. If account is not paid within 90 days of the date of service and no financial arrangements have been made, I will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

AUTHORIZATION

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to TOWN CENTER DENTAL all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions, manual or electronic. I understand that I am financially responsible for all charges whether or not paid by my insurance

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____ Date_____
(Patient, Parent, Guardian or Personal Representative)

PERSON RESPONSIBLE FOR ACCOUNT IF OTHER THAN YOURSELF

*SS#*_____ *DL#*_____

*Name*_____ *Birthday*_____/_____/_____
*Relation to patient*_____

Billing Address _____ *Apt. #*_____
*City*_____ *State*_____ *zip* _____

*Home ( )*_____ *Cell ( )* _____ *Work ( )*_____

*Employer*_____ *Occupation*_____
*Address*_____ *Suite*_____
*City*_____*State*_____*Zip*_____

I agree to be responsible for _____account.
Patient Name

Signature of Person Responsible for account_____Date_____