Dental Insurance Information

Patient name: _____ Birthdate: ____/____/_____

Insured is:☐ Self☐ Husband☐ Wife☐ Mother☐ Father☐ Other: _____

Insured's Name: _____ SSN / ID#: _____-_____-_____ Birthdate: ____/____/_____

Employer: _____ Group #: _____

Insurance Co. Name: _____ Insurance Phone #: (_____)_____
Are you covered with a second insurance company?☐ Yes☐ No

Insured is:☐ Self☐ Husband☐ Wife☐ Mother☐ Father☐ Other: _____

Insured's Name: _____ SSN / ID#: _____-_____-_____ Birthdate: ____/____/_____

Employer: _____ Group #: _____

Insurance Co. Name: _____ Insurance Phone #: (_____)_____

Authorization to Release Information and Assignment of Benefits

Please Read, Date and Sign* the Sections Below:

***Signing both sections allows us to receive payment from the insurance company on your behalf. Otherwise, you will need to pay for all services in full at the time of your dental treatment and be given an itemized statement which you can submit to the insurance company to be reimbursed.**

I give my permission for treatment to be performed for myself or my dependent child at this visit or at future visits. I hereby authorize Maple Park Dental, insurer or other organization to release any information regarding the dental history, treatment, or benefits payable for this claim of the Plan administrator or its authorized agent for the purpose of determining benefits payable.

X _____ Date: ____/____/_____
Patient or parent/guardian

I understand that I am financially responsible for care provided and that insurance is considered a method of reimbursement, but is not a substitution for payment. I authorize my signature to be "on file" for the processing of dental claims on my or my family's behalf and authorize benefits to be paid directly to Maple Park Dental, Dr. Julie Romanelli or Dr. Magdaleno Nucum.

I understand that deductibles, co-payments and non-covered services are **my responsibility to pay at the time of service** unless other arrangements have been made. A 1½ % finance charge will be added to balances over 60 days old.

X _____ Date: ____/____/_____
Patient or parent/guardian

Please give a member of our office staff your dental insurance card so that they may make a copy. Thank you.

RESET PRINT