## **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: Are you covered with a second in	Insurance Phone #: () surance company? ☐ Yes ☐ No	
Insured is: ☐ Self ☐ Husband ☐	Wife□ Mother□ Father□ Other:	
Insured's Name:	SSN / ID#:	Birthdate://
Employer:	Group #:	
Insurance Co. Name:	Insurance Phone #: ()	
given an itemized stateme I give my permission for to I hereby authorize Maple Park Den	o pay for all services in full at the time ent which you can submit to the insur- reatment to be performed for myself or my de- tal, insurer or other organization to release and his claim of the Plan administrator or its author-	ance company to be reimbursed.  spendent child at this visit or at future visits y information regarding the dental history,
X	Date:/	_/
Patient o	r parent/guardian	
reimbursement, but is not a substitu claims on my or my family's behalf Dr. Magdaleno Nucum. I understand that deductible	ncially responsible for care provided and that tion for payment. I authorize my signature to f and authorize benefits to be paid directly to les, co-payments and non-covered services are have been made. A 1½ % finance charge will be a service of the control of	be "on file" for the processing of dental Maple Park Dental, Dr. Julie Romanelli or e my responsibility to pay at the time of
XPatient o	r parent/guardian	_/

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