

INSURANCE INFORMATION

POLICY HOLDER _____ BIRTHDAY ____/____/____

SS# _____ I.D.# _____ POSITION _____

EMPLOYER _____ PHONE _____

ADDRESS _____

INSURANCE COMPANY _____ PHONE _____

ADDRESS _____

SECOND INSURANCE INFORMATION

EMPLOYEE _____ BIRTHDAY ____/____/____

SS# _____ I.D.# _____ POSITION _____

EMPLOYER _____ PHONE _____

ADDRESS _____

INSURANCE COMPANY _____ PHONE _____

ADDRESS _____

I AUTHORIZE RELEASE OF ANY INFORMATION CONCERNING MY HEALTH CARE AND TREATMENT FOR THE PURPOSE OF ADMINISTERING INSURANCE CLAIMS. PATIENTS WHO CARRY DENTAL INSURANCE SHOULD REMEMBER THAT PROFESSIONAL SERVICES ARE RENDERED TO THE PATIENT, NOT THE INSURANCE COMPANY. IT IS OUR POLICY TO FILE YOUR INSURANCE CLAIM/CLAIMS FOR YOU.

I HEREBY ASSIGN TO JAMES HASTEN D.D.S./ KATHLEEN CHIVARI D.D.S. ALL PAYMENTS FOR SERVICES RENDERED TO MYSELF OR MY DEPENDENT. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT PAID BY MY INSURANCE COMPANY. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR ANY COLLECTION CHARGES OR LEGAL FEES INCURED BY THE PROVIDER WHILE ATTEMPTING TO COLLECT THE DENTAL BILLS RELATED TO THIS CLAIM IF SUCH ACTIVITY BECOMES NECESSARY.

BE ADVISED: YOUR INSURANCE COMPANY MAY HAVE DEDUCTIBLES, CO-PAYS, RESTRICTIONS AND/OR LIMITATIONS THAT ARE YOUR RESPONSIBILITY. SINCE EACH PATIENT'S POLICY DIFFERS YOU WILL BE EXPECTED TO KNOW YOUR INSURANCE COVERAGE. IT IS OUR POLICY TO COLLECT ESTIMATED CO-PAYS AND DEDUCTIBLES AS SERVICES ARE RENDERED.

PATIENT SIGNATURE: _____ DATE _____

(Parent to sign if minor)