DENTAL INSURANCE INFORMATION

PRIMARY POLICY

INSURANCE NAME _____

POLICY HOLDER'S NAME _____ DATE OF BIRTH: _____

EMPLOYER or GROUP NAME:_____

POLICY ID# _____ SS # _____

POLICY GROUP # _____

SECONDARY POLICY

INSURANCE NAME _____

POLICY HOLDER'S NAME _____ DATE OF BIRTH: _____

EMPLOYER or GROUP NAME:_____

POLICY ID# _____ SS # _____

POLICY GROUP # _____

Assignment of Benefits

I consent to Scharfenberger Family Dentistry, PSC the disclosure of my protected health information to my insurance carrier in order to collect fees for service in connection with this claim. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. I also authorize and request my insurance carrier to pay directly to Scharfenberger Family Dentistry, PSC the insurance benefits.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

I understand that having dental insurance does not transfer my financial responsibility to the dental insurance company. I agree to be responsible for the payment of all services rendered on my behalf or my dependents.