INSURANCE INFORMATION

Primary Dental Insurance _____ Phone _____

Person who carries insurance _____ Date of Birth _____

Social Security or ID # _____ Employer _____

Secondary Dental Insurance _____ Phone _____

Person who carries insurance _____ Date of Birth _____

Social Security or ID # _____ Employer _____

As a courtesy to you, our office is happy to process insurance claims on your behalf. We perform routine insurance billing procedures upon verification of coverage. We will make every effort to help maximize your insurance reimbursement for covered procedures. It is important to understand, though, that the contract regarding your dental benefits is between you and your insurance company and we are not a party to that contract. Our office is not responsible for how your insurance handles your claims or for what benefits they pay. We do not guarantee that your insurance company will pay for treatment you receive from our practice.

I hereby authorize and direct payment of the dental benefits, otherwise payable to me, directly to Fallin Family Dentistry.

I agree to be responsible for all charges for dental services not paid by my dental benefit plan. I further hereby authorize that my child's health care information may be disclosed to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent to remain in effect until cancelled in writing.

I have read and understand the above terms and conditions.

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Signature of Parent/ Guardian Relationship Date