



Doc Bresler's Cavity Busters

Exceptional Dentistry for Children and Teens

David A. Bresler D.D.S. Joshua A. Bresler D.M.D. Jason M. Bresler D.M.D.
and Associates

DENTAL INSURANCE / FINANCIAL RESPONSIBILITY FORM

Patient's Name: _____

Patient's Date of Birth: _____

Patient's Social Security Number: _____

Father's Name: _____ Mother's Name: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Home Phone #: _____ Home Phone #: _____

Social Security #: _____ Social Security #: _____

Employer: _____ Employer: _____

Business Phone #: _____ Business Phone #: _____

Dental Insurance: _____ Dental Insurance: _____

ID#: _____ Group#: _____ ID#: _____ Group #: _____

DOB: _____ DOB: _____

Names and address of person responsible for child other than above:

This office is happy to cooperate with individuals who are covered by dental insurance. We only ask that you carefully read your policy to be sure that you are fully aware of any restrictions that apply to the benefits provided. Dental insurance is a contract between the patient and the insurance company for reimbursing the cost of dental services. It is not a contract between the dentist and the insurance company. I understand that I am financially responsible for all services rendered by the Dentist. I understand any co-payments, deductibles, and/or procedure cost not covered or denied by my insurance company, (including coverage termination prior to the date services are rendered) are my responsibility.

This Dental office is authorized to fill out and/or assist me to complete any and all insurance forms pertaining to services rendered.

(Parent or Guardian Signature)

(Date)