

Doc Bresler's Cavity Busters

Dental Insurance / Financial Responsibility

Patient's Name: _____

Patient's Date of Birth: _____

Patient's Social Security Number: _____

Child's Insurance: _____

ID#: _____ Group # (if applicable): _____

Father's Name: _____

Mother's Name: _____

Address: _____

Address: _____

City, State, Zip: _____

City, State, Zip: _____

Home Phone No.: _____

Home Phone No.: _____

Social Security No.: _____

Social Security No.: _____

Employer: _____

Employer: _____

Business Phone No.: _____

Business Phone No.: _____

Dental Insurance: _____

Dental Insurance: _____

ID#: _____

ID#: _____

Group # (if applicable): _____

Group # (if applicable): _____

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. I certify that the insurance(s) listed here represents all coverage(s) in place as of today.

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)

Chart #: _____