INSURANCE INFORMATION

You are responsible for your co-pay at the time treatment is rendered.

Your policy contains specific time limitations and age restrictions regarding certain procedures. Please be aware of the proposed treatment plan for **your** child. **You** are responsible for assuring that this treatment will be rendered within these eligibility limits. If in doubt, please contact **your** carriers customer service unit or refer to **your** insurance handbook of benefits.

In order to insure prompt processing of **your** insurance claims, please complete the requested information for file update. All information must be accurate and complete at the time of each visit or **you** will be totally responsible for all treatment costs.

Insurance Company: _____

Address: _____

_____

City: _____ St.: _____ Zip: _____

Group #: _____

Ins. Co. Phone: _____

#800-

Sponsor Name: _____

Address: _____

_____

City: _____ St.: _____ Zip: _____

Home Phone: _____

Work Phone: _____

Sponsor Birthdate: _____

MO. / Day / YR.

Sponsor SSN: _____

Sponsor ID#: _____

_____

Employer: _____

Dept.: _____

*If you have a secondary coverage, please complete a separate sheet.

I hereby authorize release of any medical information necessary to process this claim. I authorize payment of benefits directly to the undersigned dentist of the group insurance benefits otherwise payable to me. If insurance payment has not been received after thirty days I agree to pay the amount in question and to follow-up with my carrier regarding any delays. If refiling is necessary, I am responsible for the additional charge of $5.00 per claim.

Signature: _____ Date: _____