Dental Insurance Information (Primary)

NAME of Insured: Last	First	Middle	Is Insured a Patient? ⍒ Yes ⍒ No
Insured's Birth Date:	Social Security #:	ID#:	Group #:
Insured 's Address: Street:		City:	State: Zip Code:
Insured's Home Phone: include area code ( )	Work Phone: include area code ( )	Ext:	Cell Phone: include area code ( )

Insured's Employer Name:			Phone: include area code ( )
Employer Address: Street:		City:	State: Zip Code:

Patient's relationship to insured: ⍒ Self ⍒ Spouse ⍒ Child ⍒ Other _____

Insurance Plan Name:			Phone: include area code ( )
Insurance Address: Street:		City:	State: Zip Code:

Any additional insurance is the responsibility of the patient. At your request our office can provide you with the necessary paperwork you need to file your secondary insurance.

Conditions of Treatment

The practice depends on reimbursement from the patients for costs incurred in their care. Payment for office services are due at the time of service, unless prior arrangements have been made. Patients who carry dental insurance agree to be responsible for all charges for dental services and materials not paid by their Primary dental benefits plan. All deductibles and estimated co-payments must be paid at the time services are performed, unless prior financial arrangements have been made. I understand that I am financially responsible for all charges whether or not paid by insurance. I have received a copy of the office Financial Policy.

If treatment is necessary, patients will be given an estimate stating what treatment is planned and what the approximate cost will be. Financial arrangement can be discussed at this time. I understand that fees quoted in my estimate are valid for a period of six months from the date of the patient examination.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to my healthcare.

I hereby give, Gregory M. Becker DDS, consent to use and disclose my protected health information to carry out treatment, payment activities, and healthcare operations.

Release of Information To Insurance
Once 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, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to the claim.

Assignment of Benefits
I hereby authorize payment of dental benefits otherwise payable to me, directly to Gregory M. Becker, DDS. This **"Signature On File"** will be valid from this date and expire in one year. A photocopy of this document may act as an original.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. I have read the above conditions of treatment and agree to their content.

Signature of Patient/Legal Guardian: Date: