Insurance Information

We are pleased that you have dental insurance and we will be glad to assist you in obtaining the maximum benefits specified in your contract. You must realize that your benefit program is a contract between you, your employer and the insurance company. We are not party to that contract. *We can generally give you an approximate estimate of your insurance benefit, but we are not responsible for any discrepancy between the estimated benefit and the actual benefit.* We must emphasize that as dental care providers, our relationship is with you, not your insurance company. *While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered.*

PRIMARY INSURANCE

Employee Name:_____ **DOB:**_____ **SSN/ID#:**_____

Employer Name:_____ **Ofc. Phone:**_____ **Ins. Name:**_____

Ins. Address: _____ **Ins. Phone:**_____

Family Members Covered:_____

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SECONDARY INSURANCE

Employee Name:_____ **DOB:**_____ **SSN/ID#:**_____

Employer Name:_____ **Ofc. Phone:**_____ **Ins. Name:**_____

Ins. Address: _____ **Ins. Phone:**_____

Family Members Covered:_____

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Assignment of Benefits

The undersigned in requesting examination and/or treatment authorizes the release of all information including x-rays relating to that examination or treatment to health service plans and insurance companies. The undersigned also authorizes the release of such information to any peer review committee or state and local dental associations which may request it.

The undersigned hereby releases payment directly to Bel Air Dental Care of the group insurance benefits otherwise payable to the undersigned but not to exceed the actual charges for the covered services. The undersigned agrees to be financially responsible for any charges not covered by the group insurance benefits.

Signed:_____

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DO NOT COMPLETE - FOR OFFICE USE ONLY

Group#:_____ **Effective Date:**_____ **Renew Date:**_____ **Annual Maximum:**_____

Ind. Ded:_____**Fam.Ded:**_____**Prev:**_____**%Basic:**_____**%Major:**_____**%Endo:**_____**%Perio:**_____**% Surg:**_____**%**

Sealants:_____**% up to age**_____ **FlTx:**_____**% up to age** _____ ***Allow 1x or 2x per year*** **Occ. Guard:**_____

Frequency Limitations:

Periodic Exam/Prophy: 1x q 6 months or 2x per year anytime (does this include emergence exam)_____

Bitewings: 1x q 12 months or 2x per year Pano/FMX: 1x _____ **years**

History:

Last Exam:_____ **Prophy:**_____ **BWX:**_____ **Pano/FMX:**_____