Patient Dental Insurance

Patient Name: _____

Full Time Student? □ **Yes**: _____ □ **No**
Name of School

- As a courtesy, we can submit your dental claims to your primary dental benefit plan. Please provide current and accurate information each time you receive treatment to assure prompt processing of claims.
- All dental benefit information you receive from any source is subject to change by your dental benefit plan at any time.
- No insurance company will guarantee payment until the dental claim has been paid. All dental services are your financial responsibility and you are responsible for payment in full for any amount not paid by your dental benefit plan. The total balance is due on the 60th day after treatment whether insurance has paid or not.
- Estimates given of expected dental benefits by this office do not relieve the patient of responsibility to pay for all services.

***PRIMARY Subscriber*: ☐ 'Patient' & sign below or ☐ _____ & please complete the following:**
Relationship to Patient

Last Name _____ **First** _____ **Middle** _____

Date of Birth _____ **Gender**: □ M □ F **SS#** _____ - ____ - _____ **Ins ID #** _____

Address _____ **City, ST** _____ **Zip** _____

Home Phone # _____**Work Phone #** _____ **Mobile Phone #** _____

Employer _____ **Insurance Co.** _____ **Group #** _____ **Tel #** _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the above named insurance company and assign directly to Windsor Dental Group all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Windsor Dental Group may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I have read and understand the above Assignment and Release.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient