



**PRIMARY CARRIER:**

Name of Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ SS# \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Name of Employer \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**SECONDARY CARRIER:**

Name of Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ SS# \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Name of Employer \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

***PLEASE NOTE:** We will provide a computer-generated insurance form following each visit and submit the insurance form to your insurance company. A pretreatment estimate will be submitted to your insurance company **upon request only**. Please check with your insurance company to determine pretreatment filing requirements. Patients are often confused about how much the insurance company will pay. Percentages are reimbursed based on the insurance company's table of allowance - not the dentist's charges.*

*You are responsible for the full payment of the services charged.*

**PLEASE ACKNOWLEDGE YOU HAVE READ THE ABOVE BY SIGNING BELOW:**

Signature \_\_\_\_\_ Date \_\_\_\_\_