

IVERSON DENTAL, INC

DENTAL INSURANCE INFORMATION

PATIENT NAME _____ BIRTHDAY _____

PRIMARY INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

ADDRESS OF INSURED _____ CITY, STATE _____ ZIP _____

HOME PHONE # OF INSURED _____ CELL # OF INSURED _____

BIRTHDATE OF INSURED _____ INSURANCE ID #(USUALLY SOC. SEC #) _____

INSUREDS EMPLOYER _____ EMPLOYER ADDRESS _____

EMPLOYER CITY, STATE, ZIP _____ EMPLOYER PHONE # _____

INSURANCE COMPANY _____ INSURANCE ADDRESS _____

INSURANCE CITY, STATE, ZIP _____ INSURANCE PHONE # _____

GROUP OR POLICY # _____

SECONDARY INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

ADDRESS OF INSURED _____ CITY, STATE _____ ZIP _____

HOME PHONE # OF INSURED _____ CELL # OF INSURED _____

BIRTHDATE OF INSURED _____ SOC. SEC # OR EMP ID OF INSURED _____

INSUREDS EMPLOYER _____ EMPLOYER ADDRESS _____

EMPLOYER CITY, STATE, ZIP _____ EMPLOYER PHONE # _____

INSURANCE COMPANY _____ INSURANCE ADDRESS _____

INSURANCE CITY, STATE, ZIP _____ INSURANCE PHONE # _____

GROUP OR POLICY # _____

IF YOU HAVE DENTAL INSURANCE, WE ARE HAPPY TO PROCESS YOUR CLAIMS FOR YOU. YOUR ESTIMATE INSUANCE CO-PAY IS DUE THE DAY OF THE APPOINTMENT UNLESS OTHER ARRANGEMENTS ARE MADE.

I UNDERSTAND THAT MY DENTAL INSURANCE IS A CONTRACT BETWEEN THE INSURANCE CARRIER AND ME, NOT BETWEEN THE INSURANCE CARRIER AND THE DENTIST. I AM RESPONSIBLE FOR ALL DENTAL FEES. I, HEREBY, AUTHORIZE PAYMENT DIRECTLY TO DR. IVERSON, THE DENTAL INSUANCE BENEFITS OTHERWISE PAYABLE TO ME. I GRANT THE RIGHT TO THE DENTIST TO RELEASE DENTAL AND MEDICAL HISTORIES AND OTHER INFORMATION ABOUT DENTAL TREATMENT TO THIRD PARTY PAYERS (THE INSURANCE). I UNDERSTAND THAT I WILL BE CHARGED FOR ALL DENTAL TREATMENT. ANY PAYMENTS RECEIVED BY DR. IVERSON FROM MY INSURANCE COVERAGE WILL BE CREDITED TO MY ACCOUNT OR REFUNDED TO ME IF I HAVE PAID THE DENTAL FEES INCURRED.

SIGNATURE OF RESPONSIBLE PARTY

DATE