DENTAL INSURANCE INFORMATION

Patient Name: ____

Name of Subscriber: ____

SS # of the Subscriber: _____-_____-_____ DOB of Subscriber: _____-_____-_____

Employer: ____ Work # ( ) _____-_____

Address of Employer:____
Street City State Zip

Name of Insurance Company: ____________________________How much is your deductible? ______

Insurance Address: ____
Street City State Zip

Max. Annual Benefit: ____________________ How much have you used? _________________

Do you have secondary insurance? **____ Yes ____ No** **If yes, complete the following?**

Name of Insured: _____________________Relationship: ______________ DOB: _____-_____-_____

SS #: _____-_____-_____ Employer: ____________________ Date Employed: _____/_____/_____

Address of Employer:____
Street City State Zip

Name of Insurance Company: _________________________ How much is your deductible? ________

Insurance Address: ____
Street City State Zip

Max. Annual Benefit: ____________________ How much have you used? _________________

I authorize release of information acquired in the course of my examination or treatment to any insurance company to which a claim for payment and /or a request for preauthorization of such has been submitted.

I authorize payment of insurance benefits directly to Dr. Ghiassi; otherwise I will pay in full at time of service. I understand that I am responsible for any portion not paid by my insurance benefits which may include policy imitations, annual deductibles and maximums

I also understand that a service charge of 18% per annum will be added to charges which remain unpaid for a period exceeding sixty (60) days.

Signature: ____ Date: _____/_____/______
(If patient is a minor, Parent or Guardian must sign.