

"Creating healthy, beautiful smiles....for a lifetime."

Insurance Information

Name of Insured: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Home phone: _____ Work phone: _____ SS# _____

Employed by: _____

Address: _____ City/State/Zip: _____

Insurance Contact person or department: _____

Your relationship to the insured: _____

If patient is a minor, name and address of responsible party for payment: _____

_____ Relationship: _____

Primary Insurance Company Name: _____

Address: _____ City/State/Zip: _____

Phone #: _____ Group# : _____ Policy# : _____

Do you have secondary dental insurance coverage? Yes ___ No ___ If so, with whom? _____

Coverage

Preventive _____ Cal. Year _____

Basic _____ Deductable _____

Major _____ Maximum _____

Ortho _____ Other _____

Acknowledgement _____

I hereby certify that the above information is correct. It is the patient's responsibility to file their own secondary dental insurance coverage. I understand that insurance may not cover all costs of treatment and I agree to pay my balance, 1% interest/month, and/or all costs of collection insured by Metro Dental Associates. A \$25.00 fee is charged for appointments canceled or broken without 24 hours advance notice.

Signature: _____ **Date:** _____