SCHNEIDER FAMILY DENTISTRY

PATIENT INSURANCE INFORMATION

Patient Name ______________________ **Date of Birth** ______________________

PRIMARY INSURANCE POLICY

Insurance Company	______________	**Employer**	______________
Policy Holder Name	______________	**Group ID**	______________
Policy Holder DOB	______________	**Policy #**	______________
Policy Holder SSN	______________	**Insurance Co Phone**	______________
Relationship to Patient	______________	**Insurance Co Address**	______________

SECONDARY INSURANCE POLICY

Insurance Company	______________	**Employer**	______________
Policy Holder Name	______________	**Group ID**	______________
Policy Holder DOB	______________	**Policy #**	______________
Policy Holder SSN	______________	**Insurance Co Phone**	______________
Relationship to Patient	______________	**Insurance Co Address**	______________

Authorizations *(please initial by each statement)*

______ I hereby authorize Schneider Family Dentistry to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier, or in the case of Medicare Part B Benefits, to the Social Security Administration and Healthcare Financing Administration. A copy of the authorization my be used in place of the original. This authorization may be revoked by either my insurance carrier or me at any time in writing.

______ I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to Schneider Family Dentistry for the services rendered. I further authorize the release of any information needed for processing my insurance claims. A copy Of this authorization may be used in place of the original. I understand and agree that I am financially responsible for charges not paid by my insurance company.

______ I hereby assume financial responsibility for and agree to make payment in full to Schneider Family Dentistry for all charges for services or medical supplies furnished to the above-named patient not otherwise authorized of paid by my insurance carrier. Payment is to be made within 30 days as statements are presented with settlement in full, or payment arrangements are to be completed to the best of my knowledge, and I further authorize Schneider Family Dentistry to investigate any and all financial information concerning this or related claims.

______ I understand that in certain circumstances medicare may decide that appropriate medical services are not medically reasonable or necessary under the medicare law. Since medicare may deny payment for these services, I agree to be personally and fully responsible for payment of these charges.

Patient Signature: ______________________________ **Date:** ____________

(To be signed by patient's parent or legal guardian if patient is a minor)