DENTAL INSURANCE FORM

New Life Dental Center, Inc.
1881 N. CC Hwy * Nixa, MO 65714
417-725-4746

Dental Insurance Information **We do not file secondary insurance**

Patient's name: First_____M.I.____Last_____DOB_____

_____

Policy holder is the person who ***carries the insurance,*** usually through their employer.

Policy holder's name: First_____M.I._____Last_____

DOB_____Relationship to patient_____SS#_____

Policy holder's address:_____City_____State_____Zip_____

Policy holder's employer_____ Employer's address_____

City_____State_____Zip_____Employer's phone_____

Dental insurance name _____Group number _____

Policy holder ID# **(if different than SS#)** _____

Patient's ID# **(if different than policy holder's)** _____

If patient is over 18, is he/she currently enrolled in college? (Please circle) Yes No

If yes, name of school_____

(Please circle one) Full time student Part time student

Insurance filing – Filing insurance claims is a courtesy; you are expected to know your benefits. If insurance does not pay your bill including what we estimated, we will not be responsible for collecting from your insurance company. The patient is personally responsible for payment of all dental services. **You will need to pay your deductible and percentages on the date services are rendered.** Composite (tooth-colored) fillings are now the standard of care, amalgam (silver) is not. Some insurance companies will not pay the difference for a composite filling on a back tooth. If this is the case with your insurance, you will owe the difference. If you would like an amalgam filling, you will need to request so. **We can only ESTIMATE what your insurance should pay, you are responsible for all fees not covered by insurance and will receive a bill for any unpaid amount.** If we cannot verify your insurance coverage, you are responsible for all fees incurred.

I have read and completed all items in good faith and as accurately as possible. I authorize payment of dental benefits to be paid directly to the provider/dental office.

Signature on file_____Date_____