FINANCIAL / INSURANCE FORM

TO BE COMPLETED BY ALL INSURANCE OR CREDIT PATIENTS

PATIENT INFORMATION

NAME _____
LAST FIRST M.I.

ADDRESS _____
STREET

_____
CITY STATE ZIP CODE

PHONE _____ / _____ / _____
WORK HOME CELL

E-MAIL _____

S.S.# _____ SEX M or F

DATE OF BIRTH _____

SPOUSE'S OR PARENT INFORMATION

NAME _____
LAST FIRST M.I.

ADDRESS _____
STREET

_____
CITY STATE ZIP CODE

PHONE _____ / _____ / _____
WORK HOME CELL

E-MAIL _____

S.S.# _____ SEX M or F

DATE OF BIRTH _____

DOES ANY MEMBER OF YOUR IMMEDIATE FAMILY HAVE AN ACCOUNT WITH US? _____

IS THERE DENTAL INSURANCE? YES or NO (Circle)

PRIMARY INSURANCE

INSURED'S NAME _____

INSURED'S ADDRESS _____

EMPLOYER _____

GROUP # _____

I.D. # _____

INSURANCE COMPANY _____

INSURANCE COMPANY ADDRESS _____

FAMILY OR INDIVIDUAL COVERAGE? _____

RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE

INSURED'S NAME _____

INSURED'S ADDRESS _____

EMPLOYER _____

GROUP # _____

I.D. # _____

INSURANCE COMPANY _____

INSURANCE COMPANY ADDRESS _____

FAMILY OR INDIVIDUAL COVERAGE? _____

RELATIONSHIP TO PATIENT _____

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT _____

IF YOUR CLAIM HAS NOT BEEN PAID WITHIN 30 DAYS AFTER DATE OF SERVICE, IT IS YOUR RESPONSIBILITY TO CALL YOUR INSURANCE COMPANY TO CHECK ON THE STATUS OF SUCH CLAIM(S).

IF YOU WISH FOR CREDIT TO BE EXTENDED, WE FINANCE THROUGH CARE CREDIT. INQUIRE WITHIN.

I have completed to the best of my knowledge the above form. I also understand that I am responsible for any debt incurred at your office. I also wish for any insurance payment to go directly to John F. Dunbar, Jr., P.A.

SIGNATURE _____ DATE _____
(PATIENT SIGNATURE OR LEGAL GUARDIAN)

Please bring a dental insurance form every time you come to the office, and complete patient's portion.
This helps us to help you collect your insurance benefits.

THANK YOU MOST OF ALL FOR CHOOSING TO COME TO OUR OFFICE!!