

INSURANCE INFORMATION

Primary Insurance

Primary Insurance _____

Employee's Name _____

Date of Birth _____

Employer _____

Insurance Company _____

Their Address _____

City/State/Zip _____

Their Phone _____

Group Number _____

Secondary Insurance

Secondary Insurance _____

Employee's Name _____

Date of Birth _____

Employer _____

Insurance Company _____

Their Address _____

City/State/Zip _____

Their Phone _____

Group Number _____

Agreement

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status.

I authorize the staff of Dental Group West to perform, with my consent, any necessary dental services I may need during diagnosis and treatment. I understand that payment for any given service is due at the time of treatment unless prior arrangements have been made. I further understand that I am completely responsible for this account regardless of insurance benefits.

Signature _____

Date _____

Doctors Signature _____

Date _____

Thank you for completing this form. It will enable us to help you more effectively. If you ever have any questions or concerns, please ask us. We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA (Occupational Safety & Health Administration), C.D.C. (Center for Disease Control), and the A.D.A. (American Dental Association).