As a courtesy to our patients, we are happy to assist you in completing your insurance forms. However, WE DO NOT ACCEPT DIRECT PAYMENT FROM INSURANCE COMPANIES. Your payment is due when services are rendered. We accept the following payment methods: Cash, Cheque, Visa, MasterCard, and Debit Cards.

Please fill out the information below as completely as possible to allow us to help you with our computerized insurance forms.

Primary Insurance

Patient Name: --

Name of Policy Holder (if Different): ---

Birth Date of Subscriber: --
Day Month Year

Patient's Relationship to Subscriber: --

Name of Insurance Company: ---

Group or Plan Number: -----------------------------Division: --

ID/Certificate: --

Name of Employer: --

Employer's Address: --

If You Have Co-Insurance, Please Complete Part Two

Name of Policy Holder: ---

Relationship to Patient: ---

Birth Date of Subscriber: --
Day Month Year

Name of Insurance Company: ---

Group or Plan Number: -------------------------------Division: --

ID/Certificater: --

Employer's Name: ---

Employer's Address: --

I authorize release, to my dental benefits plan administrator and CDA, information contained in claims submitted electronically.

The authorization shall continue in effect until undersigned revoked the same.

____ ________________

Signature of patient, parent or guardian Date