Dental Insurance

Name of Dental Insurance Company _____

Your insurance is a contract between you and your insurance company. If, for any reason, your insurance fails to pay, YOU are responsible for FULL payment.

I authorize release of any information necessary to process my dental insurance claims. I understand that I am responsible for all costs of dental treatment.

Sign_____ Date_____

(Patient or Parent of Minor)

I hereby authorize payment directly to Eastman Family Dental Center of the insurance benefits otherwise payable to me.

Sign_____ Date_____

(Insured Person)

Uninsured

I understand that payment is due on the date services are rendered and accept full responsibility of payment for services provided.

Signed _____ Date _____

**If the insurance is drawn on your spouse or parent/guardian, please list the following information:

Subscriber Name: _____

Date of Birth: _____

SSN: _____