Insurance Information

Cascade View Family Dental
General & Family Dentistry

Name of Dental Insurance/Benefit Plan

_____

Company/Business Administering Plan _____

Phone _____ Insurance Email _____

Contract #_____ Group #_____

Subscriber #_____

Name(s) of other dependents under this plan

_____

_____

_____

Is patient covered by additional insurance? ___ Yes ___ No

Subscriber Name _____Relation to Patient_____

Birthdate_____ Soc. Sec # _____

Address (if different from patient) #_____

City_____ State _____ Zip _____

Home Phone_____ Cell Phone _____

Email_____

Subscriber Employed by_____

Business Phone_____ Business Email _____

Insurance Company_____

Phone _____Insurance Email _____

Contract #_____ Group #_____

Subscriber #_____

Name of other dependents under this plan: _____

_____

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.