Borengasser
Family Dental

DENTAL INSURANCE

Who is responsible for this account?_____ S.S.# _____

Birthdate_____ Relationship to patient _____

Insurance Co. _____

Group # _____ ID # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name_____

Birthdate_____ S.S. #_____

Relationship to Patient _____

Insurance Co. _____

Group # _____ ID#_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with_____

_____

and assign directly to **Borengasser Family Dental** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian, or Personal Representative

_____

Please print name of Patient, Parent, Guardian, or Personal Representative

_____ _____

Date **Relationship to Patient**