PEDIATRIC DENTISTRY OF NORTHBROOK & HIGHLAND PARK

INSURANCE INFORMATION

Patient(s) full name: _____ D.O.B:_____

Policy Holder's name: _____ D.O.B: _____

Social Security #: _____ I.D. #: _____ Group #: _____

Employer's name: _____ Insurance Company: _____

Insurance Telephone #: _____ Insurance Billing Address: _____

_____

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Electronic Payer I.D. #: _____ Effective Date: _____ Calendar Year: _____

Annual Deductible: ***PREVENT. BASIC & MAJOR*** Ind. $ _____ Fam. $ _____ Annual Max $ _____

Preventative Services:	INSURANCE %	PATIENT %
_____ Exams, _____ Prophy		
_____ Fluoride up to age _____	_____%	_____%
_____ BWX, PAN/FMX _____		
Sealants _____% up to age _____		
Molars/Premolars _____		
Basic Procedures:		
Amalgams/Resins/Composites	_____%	_____%
Oral Surgery		
Pulps		
Major Procedures:		
SSC Crowns	_____%	_____%
Endodontics		
Prosthetics/Dentures		

Verified on: _____ By whom: _____

These benefits are simply **estimates** based on your current coverage, if your policy changes, your benefits may also change. Please notify us of any changes prior to your appointment. As a **courtesy**, our office will submit insurance pre-estimates and bills at no charge to you; however, your insurance is a contract between you and your insurance carrier. Your portion **must** be paid at the time of service. For major procedures, payment arrangements will be discussed with you prior to rendering services.

Assignment of insurance benefits for dental procedures:

I have read the above and fully understand that I am financially responsible for all professional charges not covered by my insurance plan(s).I authorize insurance payments to be made directly to the dentist(s) involved in the patients' care.

Signature: _____ Date: _____