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 Name: _____ Insurance Telephone #: _____

Insurance Billing Address: _____

PLEASE BE ADVICED, SERVICES WILL NOT BE BASED ON COVERAGE. 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. Our office will submit insurance pre-estimates and claims as a **courtesy** and at no cost to you; however, your insurance is a contract between you and the carrier. The final coverage will be determined by the insurance once claims are processed. 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: _____

BELOW IS FOR OFFICE USE ONLY **BELOW IS FOR OFFICE USE ONLY** **BELOW IS FOR OFFICE USE ONLY**

Electronic Payer ID:_____ Effective Date: _____ Calendar/Benefit Year: _____

Annual Deductible Applies to **PREV BASIC MAJOR** Ind $_____ Fam $_____ Annual Maximum $_____

PREVENTATIVE	**INSURANCE %**	**PATIENT %**
_____ Exams _____ Prophylaxis/Cleanings _____ Fluoride to/under Age _____ _____ BWX _____ PAN/FMX _____ Sealants to/under Age _____ @ _____**%** Molars/Premolars _____	_____ %	_____ %
BASIC RESTORATIVE		
Resins/Composites Extractions/Oral Surgery Pulpotomies/RCT	_____ %	_____ %
MAJOR TREATMENT		
SSC Crowns Endodontics	_____ %	_____ %

Verified on: _____ By whom: _____