# BIDDEFORD SACO DENTAL ASSOCIATES, PC

# INSURANCE INFORMATION

Primary Insurance Information

Patient Name: _____ Date: _____

Name of Insured: _____ Relationship to Patient: Self Spouse Child Other

Insured SSN: _____ Insured Date of Birth: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Phone: _____ Phone: _____

ID#: _____

Group#: _____

Group Name: _____

Assignment of Benefits

The undersigned patient, in requesting examination and/or treatment, authorizes the release of all information (including x-rays) relating to that examination or treatment to health service plans and insurance companies.

The undersigned patient also authorizes the release of such information to any peer review committee or state and local dental associations which may request it.

I hereby authorize payment directly to Biddeford Saco Dental Associates of the group insurance benefits otherwise payable to me, but not to exceed the actual charges for the covered services. I understand that insurance companies do not guarantee payment in advance therefore I am financially responsible for any charges not covered by the group insurance benefits and that payment is due at the time of service.

Patient Signature:_____ Date: _____

Responsible Party Signature: _____ Date: _____