

MARIETTA DENTAL ASSOCIATES INSURANCE INFORMATION

EMPLOYER _____ PHONE#() _____

EMPLOYER ADDRESS _____

CITY _____ STATE _____ ZIP _____

INSURANCE CO. _____ GRP# _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

INS. CO. PHONE#() _____

SUBSCRIBER _____ DOB _____ SS# _____

PATIENT _____ DOB _____ SS# _____

RELATIONSHIP TO SUBSCRIBER _____

I understand that Marietta Dental will file insurance as a courtesy to their patients, but it is my responsibility to know the complete information needed from my insurance carrier in order for it to be filed correctly. Marietta Dental cannot accept responsibility regarding my insurance, and makes no warranties toward my specific dental insurance policy. This office treats patients that are represented by hundreds of different employers and insurance carriers, and does not verify eligibility or update benefits per individual.

I understand that my insurance plan is solely my benefit, and I am responsible for paying my estimated percentage of treatment fees at the time the service is rendered and any remaining balance after insurance makes payment.

signature

date