FORT WORTH

pediatric

DENTISTRY

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Diplomates of the American Board of Pediatric Dentistry

Insurance Information

As a courtesy, we will file your dental insurance, **however**, in order to do so, we require **all** of the information below at the time of service. **If the information is incomplete, you will be required to pay in full at the time of service** and we will provide you with an itemized receipt that you may use to file for reimbursement. **If you were not provided an insurance card, one can typically be obtained by logging into your dental insurance company website.**

PRIMARY DENTAL INSURANCE:

Patient's Name(s)____

Employee's Full Name: ____________________ Employee's Date of Birth: __________

Relationship to Patient: ____________________ Work Phone Number: __________

Social Security #: ____________________ (Subscriber) ID#__________

Insurance Company Name: ____________________ Group Number:__________

Claims Mailing Address:____________________ City:__________

State/Zip: ____________________ Insurance Company Phone#: __________

Employer Name: ____________________ Employer City/State:__________

Address of Employee if different than patient: ____________________

ASSIGNMENT OF INSURANCE BENEFITS

In consideration of services rendered, I hereby transfer and assign to: Fort Worth Pediatric Dentistry, PLLC 6210 John Ryan Drive, Suite 100, Fort Worth, Texas 76132, all rights, and title and interest in any payment due me for services as provided in the policy or policies of insurance held by me. I agree to pay, at Fort Worth, Tarrant County, Texas, the charges of Fort Worth Pediatric Dentistry which exceed the amount paid by the policies held by me. I further agree and authorize the above named dentist to release any information requested by the insurance company(s) or its representatives. The undersigned accepts full responsibility for the account.

Policy Holder or Authorized Agent:____________________ Date: __________

Your dental insurance is your financial responsibility. Regardless of what is calculated as your dental benefit in dollars, we must stress the fact that you are responsible for the total cost of your dental treatment. As a courtesy to you, Fort Worth Pediatric Dentistry will file your insurance claims and ask that you pay an estimated portion based on typical dental insurance coverage at the time of service. <u>Our office is out of network for all insurance plans and you are responsible for any remaining balance after insurance has paid.</u>

focused dentistry for infants, children & teens