Insurance Information

All dental information and cards are required at the time of services for insurance submissions. Otherwise, patient is responsible for all balances the day of service.

Patient Name: _____ Phone: _____

Patient Address: _____ Cell: _____

Parent(s) Name(s) (under 18): _____

Primary Dental Insurance Information:

Subscriber Name: _____ Phone: _____ Cell: _____

DOB: _____ Relationship to Patient: _____

Address: _____

Employer: _____ Subscriber ID#: _____ SSN#: _____

Group #: _____ Insurance Co Name: _____

Secondary Dental Insurance Information:

Subscriber Name: _____ Phone: _____ Cell: _____

DOB: _____ Relationship to Patient: _____

Address: _____

Employer: _____ Subscriber ID#: _____ SSN#: _____

Group #: _____ Insurance Co Name: _____

I, _____ understand that the insurance information I submitted is correct to the best of my knowledge, and I understand that my insurance is a contract between the insurance company and myself. I understand that KS Dental PC as a courtesy will submit the insurance information provided, and I am responsible for all deductibles, copays, balances, interest, and collectable fees, if applicable, on services rendered for any family members and myself whom I present to KS Dental PC.

Patient's Signature _____

Parent Signature (if under 18) _____