Dental Benefits Information

Patient Name _____ Date of Birth _____

Insured's Name _____

Date of Birth _____ SS# _____

Employer and Address _____

_____ Employer Phone # _____

Insurance Company Name _____

Claims Address _____

Ins. Carrier's Phone Number _____

ID # _____ Group # _____

If you have dual or secondary coverage complete the following information
Which is primary? _____

Subscriber's Name _____

Date of Birth _____ SS# _____

Secondary Employer and Address _____

_____ Phone Number _____

Insurance Company Name _____

Claims Address _____

Ins. Carrier's Phone Number _____

ID # _____ Group # _____

I give permission for Dr. Valentine to release any and all information in order to secure benefits. I authorize all insurance payments to be made to Dr. Valentine's office. I understand that if my insurance pays me directly, I will immediately make payment to Dr. Valentine. I understand that I am responsible for the total charges. Dr. Valentine's office files insurance as a courtesy. If my insurance payment is not received within 60 days from the date of service, **I will make payment to Dr. Valentine** and I will be given an insurance claim form to seek reimbursement from my insurance carrier. I am responsible for knowing my benefit package information. **All information given by Dr. Valentine's staff is based on basic policy information and not my individual policy plan provisions.**

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SIGNATURE OF GUARANTOR