DENTAL INSURANCE INFORMATION (Please complete only if you have dental insurance)

Patient Name_______________________ D.O.B. ______________ Relationship to Insured ______________

Is patient covered under more than one dental plan? ☐ Yes ☐ No (If Yes, complete Secondary Insurance Information Section also)

Status: ☐ Married ☐ Single ☐ Divorced ☐ Legally Separated ☐ Widowed ☐ Domestic Partner ☐ Minor Child

Student Status: ☐ Full Time ☐ Part Time ☐ Not Applicable

School Info: ____

Name of School School Address City State Zip

Primary Dental Insurance Plan

Insurance Co. Name ______________________

Group Name ______________ Group # ______________

Subscriber Name ______________________

Subscriber ID or SSN ______________________

Subscriber D.O.B. ______________ Relationship to Pt. ______________

Employer ______________________

Employer Address ______________________

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Employer Phone ( ) ______________________

Secondary Dental Insurance Plan

Insurance Co. Name ______________________

Group Name ______________ Group # ______________

Subscriber Name ______________________

Subscriber ID or SSN ______________________

Subscriber D.O.B. ______________ Relationship to Pt. ______________

Employer ______________________

Employer Address ______________________

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Employer Phone ( ) ______________________

INSURANCE ASSIGNMENT of BENEFITS and PATIENT INSURANCE FINANCIAL POLICY

I certify that I, and/or my dependents have insurance coverage with ______________________

Name of Insurance Company (ies)

I agree to assign all insurance benefits, otherwise payable to me for services rendered, directly to Dr. Maryam Jackson, D.D.S.
I understand that I am financially responsible for all charges, whether or not paid by my insurance. This signature on file is my authorization for the release of information necessary to process my claims.

X Signature of Patient (Parent or Guardian if a Minor) ______________________Date______________

Please understand that your insurance plan is a contract between you and your insurance company. We will gladly complete and submit any claims for services rendered by this Office as a courtesy. Please familiarize yourself with your plan benefits. Not all plans are the same. Some may pay a fixed plan allowance for a procedure, while others may pay based on a percentage of the fee charged, and everything in between! Most plans have a variety of limitations, exclusions, frequency allowances, etc. It is your responsibility to pay any applicable deductible amount, co-insurance, or any other balance not paid by your insurance company at the time the services are rendered. Your signature below acknowledges your understanding and agreement of this policy.

X Signature of Patient (Parent or Guardian if a Minor) ______________________Date______________