



**Professional Lane
DENTAL ASSOCIATES**

"Your pathway to dental health"

Insurance Information

When most people think about insurance, they think first about their health insurance. That's a natural thing to do. However, dental insurance is very different from medical insurance. With annual maximums, waiting periods, and limitation clauses, dental insurance is designed only to offset the cost of your preventative care.

Your employer has purchased your dental insurance for you. The insurance company and your employer have negotiated your policy. These decisions are not always made with your optimal dental health in mind. However, it is our belief that each person, along with their dental professional, can freely choose the treatment that most readily satisfies their needs.

While we are happy to assist our patients with filing their insurance, **payment is ultimately the responsibility of the patient.** We allow your insurance company 60 days to make payment on your behalf. **If after 60 days, we have not received payment, the balance is the responsibility of the patient.**

To properly file your insurance, please provide the following information:

Patient: _____ Date of Birth _____

Primary Policy Holder:

Insurance Holders Name: _____

Social Security #: _____ Date of Birth: _____

Relationship to Patient: _____

Insurance Company Name: _____

Claim Address: _____ Zip: _____

Employer: _____ Phone #: _____

Contract #: _____ Group #: _____

Secondary Policy Holder:

Insurance Holders Name: _____

Social Security #: _____ Date of Birth: _____

Relationship to Patient: _____

Insurance Company Name: _____

Claim Address: _____ Zip: _____

Employer: _____ Phone #: _____

Contract #: _____ Group #: _____

I authorize the health care provider named above to submit claims for payment for services to insurance company(s) named above, on my behalf and in my name, and assign to such provider the group insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for the covered services. I understand that I am financially responsible for any charges not covered by the group insurance benefits.

Insured's Signature: _____ **Date:** _____