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Pediatric Dentistry of Central Ohio

DENTAL INSURANCE INFORMATION

Patient Information

First name: _____ Last name: _____
Date of birth: _____ Relationship to subscriber: _____

Subscriber Information

First name: _____ Last name: _____
Date of birth: _____ Social security number: _____
Phone number: _____

Dental Insurance

Insurance company: _____
Employer: _____ Phone number: _____
Address: _____
Group number: _____ Member ID: _____ Effective date: _____

If applicable, please provide your secondary insurance below.

Secondary Subscriber Information

First name: _____ Last name: _____
Date of birth: _____ Social security number: _____
Phone number: _____

Secondary Dental Insurance

Insurance company: _____
Employer: _____ Phone number: _____
Address: _____
Group number: _____ Member ID: _____ Effective date: _____

Disclaimer and signature

FINANCIAL POLICIES:

Payment for professional services is due at the time dental treatment is provided. If your insurance has copays and/or a deductible, the estimated amount will be collected at the time of service. If you do not have dental insurance, the full amount will be collected at the time of service. Past due accounts are subject to $5.00 monthly billing fees until the account is paid in full. Delinquent accounts are also subject to collection action after four failed attempts to collect the debt. In the event that your family account is submitted to our collection agency, the patient doctor relationship will be terminated. We will transfer any records upon your request.

Signature: _____ Date: _____