

The Atlanta Dental Group PC

PATIENT INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE CARRIER:

Insured's Name _____ SS# _____ Date of Birth _____
Insured's Employer _____ Employer's Address _____
Insurance Carrier _____ Group# _____ Phone# _____
Insurance Carrier's Address _____

SECONDARY DENTAL INSURANCE CARRIER:

Insured's Name _____ SS# _____ Date of Birth _____
Insured's Employer _____ Employer's Address _____
Insurance Carrier _____ Group# _____ Phone# _____
Insurance Carrier's Address _____

MEDICAL INSURANCE CARRIER:

Insured's Name: _____ SS# _____ Date of Birth _____
Insured's Employer _____ Employer's Address _____
Insurance Carrier _____ Group# _____ Phone # _____
Insurance Carrier's Address _____

AUTHORIZATION TO RELEASE MEDICAL/DENTAL INFORMATION:

I authorize the release of any medical/dental information necessary to process my insurance claim(s). I also certify that all insurance information given to the Atlanta Dental Group PC is correct and complete. A photocopy of my signature shall be valid as original.

Patient's Signature _____

Insured's Signature _____

AUTHORIZATION TO PAY THE ATLANTA DENTAL GROUP PC:

I hereby authorize my insurance company to pay by check made out to and mailed directly to: Atlanta Dental Group PC, the expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment shall not exceed the total charges for the services performed by The Atlanta Dental Group PC. I agree to be responsible for my bill and any portion that the insurance company does not pay. I will pay any balance remaining within 90 days. I understand that the Atlanta Dental Group PC and its dentists are not part of any PPO or DMO plans. I understand that the staff of The Atlanta Dental Group PC **cannot guarantee how much, or even if, my insurance company will pay** on a claim, since the insurance company has a contract with me and not with the Atlanta Dental Group PC and insurance plans vary widely in their allowable fees and covered charges. I further agree to immediately sign over to the Atlanta Dental Group PC, without cashing, any insurance payments sent to me. If I should cash and hold these funds, I agree to pay the Atlanta Dental Group PC a **20% late fee** for the amount of any funds I may take. A photocopy of my signature shall be valid as original.

Patient's Signature: _____

Insured's Signature: _____