Babylon Dental Care of Great South Bay

785 West Montauk Highway, West Babylon NY 11704

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PLEASE COMPLETE THIS FORM SO WE CAN ALLOW ENOUGH TIME TO COMPLETE YOUR COMPLIMENTARY BENEFIT CHECK.

Patien't Name:_____M.I._____

Primary Dental Insurance

In Company Name:_____

Insurance Co. Address:_____

Telephone #:_____

Group Number:_____Union Local or Group:_____

Insured's Name:_____

Relation:_____

Insured's Birthday:____/____/_____ Social Security #:_____

Insured's Employer:_____

Patient's Birthday:____/____/_____

School Name if Attending:_____ ☐ FullTime ☐ Part Time

**Please make sure your insurance has current records on your student status*

Secondary Dental Insurance

Insurance Co. Name:_____

Insurance Co. Address:_____

Telephone #:_____

Group Number:_____ Union Local or Group:_____

Insured's Name:_____

Relation:_____

Insured's Birthday:____/____/_____ Social Security #:_____

Insured's Employer:_____

RELEASE:

I authorize the dentist to perform any diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my care payor.

I attest to the accuracy of the information on this page.

_____ _____

Patient's or Guardian's Signature Date