Babylon Dental Care

GREAT SOUTH BAY GATEWAY PLAZA

Tel: 631-983-6665 • Fax: 631-587-7398 • www.babylondentalcare.com

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

Patient's Name: _____ M.I. _____

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Telephone # _____ Policy # _____ Member ID # _____

Group # _____

Insured's Name: _____ Relation: _____

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

Insured's Employer: _____

Patient's Birthday: _____ / _____ / _____

School Name if Attending: _____ ☐ Full Time ☐ Part Time

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

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Telephone # _____ Policy # _____ Member ID # _____

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