Print Form

FINANCIAL & INSURANCE INFORMATION

Date _____

PATIENTS: _____ _____ _____

DOB_____ DOB_____ DOB_____

Primary Policy Holder:

Name_____

Relationship_____

Address (if different) _____

_____

Home Phone_____

Cell Phone _____

Work Phone _____

Employer _____

Soc. Sec.# _____Birthdate_____

Do you have dental insurance coverage for child? □Yes □ No

Plan Name _____

Ins. Phone No. _____

Address _____

_____

Group # _____

Policy/ID #_____

Secondary Policy Holder:

Name_____

Relationship_____

Address (if different) _____

_____

Home Phone_____

Cell Phone _____

Work Phone_____

Employer _____

Soc. Sec. #_____Birthdate_____

Do you have dental insurance coverage for child? □Yes □ No

Plan Name _____

Ins. Phone No. _____

Address _____

_____

Group # _____

Policy/ID # _____

RELEASE AND ASSIGNMENT

I certify that my minor/child is covered by insurance with _____
Name of Insurance Company

and assign directly to Dr. Michael Hilgers all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Parent/Guardian Signature _____ **Date** _____