MICHAEL S. TOSATTI, DMD
1067 Farmington Avenue • Kensington, CT 06037 • 860-828-1475
Dentistry for Adults and Children

Insurance/Payment Info

DENTAL INSURANCE INFORMATION

1. Insurance Company ______________________________

   Address ______________________________

   I.D. # ____________________ Group # ____________________

   Relationship to Insured: Self ____ Spouse ____ Child ____ Other ____

If the insurance is in someone else's name please complete:

Name of Insured Person ______________________________

Insured's Address ______________________________

Insured's Social Security Number ______________________________

Insured's Employer ____________________ Insured's Date of Birth ____________________

2. 2nd Insurance Carrier ______________________________

   Address ______________________________

   I.D. # ____________________ Group # ____________________

   Relationship to Insured: Self ____ Spouse ____ Child ____ Other ____

If the insurance is in someone else's name please complete:

Name of Insured Person ______________________________

Insured's Address ______________________________

Insured's Date of Birth ______________________________

Insured's Social Security Number ______________________________

Insured's Employer ______________________________

PLEASE READ: CONCERNING INSURANCE AND PAYMENT

1. Patients who carry health insurance should remember that insurance is a contract between the patient and the insurance company. Claims are submitted from this office as a service to you.
2. In the event your insurance company denies a claim, or only pays a portion of the claim, you are primarily responsible for any balance due.
3. Insurance deductibles are due the day the service is rendered.
4. Failed or missed appointments without a 24 hour notice of cancellation will be charged.
5. I agree that in the event that I do not pay any bills in a timely fashion, that I will pay for all responsible attorney's fees and costs for collection by Dr. Tosatti in connection with the collection of these outstanding balances.

*I authorize the release of medical information necessary to process claims for dental benefits.
I authorize payment of dental benefits to Michael Tosatti, D.M.D. for services provided.

Signature of Patient ______________________________

Date ____________________