MATUS
FAMILY DENTISTRY

DENTAL INSURANCE INFORMATION

1. Insurance Company _____

   Address _____

   ID # _____ 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. Secondary Insurance Carrier _____

   Address _____

   ID # _____ Group # _____

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

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

   Address _____

   ID # _____ Group # _____

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

PLEASE READ CONCERNING INSURANCE AND PAYMENT

1. Patients who carry health insurance should remember the 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. 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 Matus Family Dentistry 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 Matus Family Dentistry for services provided.

Patient Signature _____ Date _____