

## **FINANCIAL INFORMATION**

*(Please be sure to fill out completely.)*

### **Dental Insurance**

*We will be happy to file your primary insurance for you. You will be responsible for filing any secondary insurance. All co-pays and/or deductibles are due when services are rendered.*

Name of Employee: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Date Employed: \_\_\_\_\_ Employee's SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer's Name & Address: \_\_\_\_\_

\_\_\_\_\_ Employer's Phone #: \_\_\_\_\_

Member ID# \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Insurance Company Address (Claims Address): \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone Number to Verify Benefits (800 #): \_\_\_\_\_ Effective Date: \_\_\_\_\_

*I authorize Steiner Dental to release any information including diagnosis and the records of any treatment or examination rendered to me or my child to third party payers and/or health practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services rendered. I agree to be responsible for payment of all services rendered on my behalf or for my dependents.*

\_\_\_\_\_  
*Signature of patient (or parent if patient is a minor)*

### **Assignment of Benefits**

*I hereby authorize payment of dental benefits otherwise payable to me directly to Steiner Dental.*

\_\_\_\_\_  
*Signature of patient (or parent if patient is a minor)*

### **Referrals**

Occasionally, it may be necessary to refer patients to another medical / dental professional. If using your medical insurance for any treatment, you may need a referral authorization from your medical carrier in order to receive benefits. If a referral is necessary, the dentist may need to speak with another healthcare practitioner. This may include protected health information and treatment records.

*I understand that I am responsible for attaining any referral authorizations necessary for my medical insurance. I authorize Steiner Dental to release any information including health information, diagnosis and the records of any treatment or examination rendered to me or my dependents to other health practitioners.*

\_\_\_\_\_  
*Signature of patient (or parent if patient is a minor)*