INSURANCE INFORMATION

All Information must be provided below in order for our office to bill your insurance company. Insurance billing is a courtesy we provide to our patients. Please be prepared to provide insurance cards.

Primary Insurance Company: ____

Insured Subscriber's Name: ____

Subscriber's DOB: ______________________ Employer: ______________________________

Insured's SS# or ID#: ____________________ Group #: ______________________________

Secondary Insurance Company: ____

Insured Subscriber's Name: ____

Subscriber's DOB: _______________________ Employer: ______________________________

Insured's SS# or ID#: ____________________ Group #: ______________________________

AUTHORIZATION OF PAYMENT

Authorization for signature on file

I ______________________________, hereby authorize Burns Dental Care to affix my name to any and all claims or documents related to all dental health benefits due to myself and/or my dependents.

I assign to Burns Dental Care all payments for medical/dental services rendered to myself and/or my dependents.

I further authorize Burns Dental Care to furnish insurance carriers, utilization review groups, other physicians, and (if applicable) my attorney any information concerning my teeth and treatment.

A photocopy of these assignments/authorizations shall be valid as the original.

Patient's Signature: ____

Printed Name: ____ Date: _________________

Burns Dental Care
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