

INSURANCE INFORMATION

PRINT NAME OF PRIMARY
DENTAL INSURANCE COMPANY HERE >>>

SUBSCRIBER'S NAME: _____

DATE OF BIRTH: _____

GROUP # _____ ID# _____

SOCIAL SECURITY # _____

PRINT NAME OF PRIMARY
MEDICAL INSURANCE: HERE >>>

SUBSCRIBER'S NAME: _____

DATE OF BIRTH: _____

GROUP # _____ ID# _____

SOCIAL SECURITY # _____

SPECIALIST COPAY ON CARD _____

I authorize the release of any dental or medical information necessary to process my claim and request payment of benefits directly to Dr. Martone for services provided. I understand that I am fully responsible for any portion of these services that are not covered by my insurance benefits.

SIGN HERE _____ DATE _____

PLEASE BE AWARE THAT THE HEALTH PROVIDER IS NOT RESPONSIBLE FOR OBTAINING PAYMENT FROM THE INSURANCE COMPANY. ALTHOUGH THE HEALTH PROVIDER WILL FILE A CLAIM AS A COURTESY TO THE PATIENT, OBTAINING PAYMENT FROM THE INSURANCE COMPANY IS ACTUALLY A MATTER BETWEEN THE PATIENT AND THE INSURANCE COMPANY AND THE RESPONSIBILITY OF THE PATIENT.