FINANCIAL INFORMATION

(Please be sure to fill out completely.)

Dental Insurance

We will be happy to file your primary insurance for you, provided they will pay us directly. You will be responsible for filing any secondary insurance. All co-insurance and/or deductibles are due when services are rendered.

Name of Employee: ______________________________ Relationship to Patient: ______________

Date Employed: __________________ Employee ID# (if applicable): ______________________________

Employer's Name & Address: ____

____

Group #: ______________________________ Effective Date: ____________________________

Insurance Company Name: ____

Insurance Company Address (Claims Address): ____________________________________

City, State, Zip: ______________________________________

Phone Number to Verify Benefits (800 #): ______________________

I authorize MI MAINSTREET DENTISTRY *to release any information including diagnosis and the records of any treatment or examination rendered to me or my child to third party payors 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 MI MAINSTREET DENTISTRY

____

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 MI MAINSTREET DENTISTRY *to release any information including health information, diagnosis and the records of any treatment or examination rendered to me or my dependents to health practitioners.*

____

Signature of patient (or parent if patient is a minor)