

Responsible Party Information Patient name _____

Name of responsible party if different than patient: _____

Relationship to patient: _____ Phone number: _____

Address: _____ City: _____ State _____ Zip _____

WE DO NOT NEED YOUR HEALTH INSURANCE INFORMATION

DENTAL PRIMARY INSURANCE

DENTAL SECONDARY INSURANCE

Name of policy holder _____

Name of policy holder _____

SSN/ID# _____

SSN/ID# _____

Policy holder date of birth: _____

Policy holder date of birth: _____

Employer: _____

Employer: _____

Dental insurance company _____

Dental insurance company _____

Group # _____

Group # _____

Insurance company phone # _____

Insurance company phone # _____

- **Is there any additional insurance coverage for this patient?**
- If you have dental insurance we will gladly complete the forms necessary to process your claim. Please complete the above information regarding your coverage and bring your dental insurance card and photo identification with you to your appointment.
- We have no control over the limitation and policies of your insurance plan. We will estimate what your insurance company may pay, but it is the insurance plan that you are contracted with that makes the final determination of your benefits. Please feel free to contact our office at (616)455-7370 if we can help you with your insurance and billing questions.
- All co-pays and deductibles are due at the time of service.
- For your convenience we accept payments made by cash, check, Visa, MasterCard, Discover, American Express, as well as through Care Credit, which is a financial institution that allows our patients to make payments over a period of three or six months (interest free). Care Credit can be contacted at www.carecredit.com or by phone at (800) 365-8295. Online bill payment is available at www.hoekwaterdental.com
- I authorize release of information relating to dental claims, authorize insurance payment directly to Hoekwater Family Dentistry and accept responsibility for the costs of dental treatment.
- **Signature** _____ **Date:** _____