Responsible Party Information **Patient name_____**

Name of Responsible Party if different than patient:_____

Relationship to Patient:_____Phone number:_____

Address:_____City_____State_____Zip_____

Insurance Information

Primary Insurance: (please provide your insurance card) Insurance phone number_____

Name of policy holder_____Employer:_____

Address of policy holder_____Phone number of policy holder_____

ID #:_____Date of birth:_____

Name of Dental Insurance Co._____Group #_____

Address to send claims to_____City_____State_____Zip_____

Secondary Insurance (please provide your insurance card) Insurance phone number_____

Name of policy holder_____Employer:_____

Address of policy holder_____Phone number of policy holder_____

ID #:_____Date of birth_____

Name of Dental Insurance Co._____Group #_____

Address to send claims to_____City_____State_____Zip_____

- **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 limitations 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, 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. Please feel free to contact our office at (616) 455-7370 if we can help you with your insurance and billing questions.

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:_____