Insurance Worksheet

We, at Princeton Dental, are happy to assist you by filing dental claims with your insurance company on your behalf. Due to the increased number and complexity of insurance plans available, and in order to insure that you receive the maximum benefit available, in a timely manner, please familiarize yourself with your insurance policy and any special requirements and/or limitations within.

Date_____

Name of Patient:_____

Subscriber's Name Primary Insurance:_____

Relationship to Patient: ___Self ___Spouse ___Child ___Other
Social Security No. _____-_____-_____ Date of Birth:____/____/____
Employer Name:_____ Work Phone:___-___-___ Ext:_____
Insurance Company Name _____
Group No._____ ID No._____
Insurance Co. Claims Address: _____
City: _____ State: _____Zip:_____
Insurance Co. Phone No.:____-____-_____ Electronic Payer ID No._____

Subscriber's Name Secondary Insurance:_____
Relationship to Patient: ___Self ___Spouse ___Child ___Other
Social Security No. _____-_____-_____ Date of Birth:____/____/____
Employer Name:_____ Work Phone:___-___-___ Ext:_____
Insurance Company Name _____
Group No._____ ID No._____
Insurance Co. Claims Address: _____
City: _____ State: _____Zip:_____
Insurance Co. Phone No.:____-____-_____ Electronic Payer ID No._____

Assignment and Release: I certify that the above information is correct. I hereby authorize my benefits to be paid directly to Princeton Dental, P.A. and I am financially responsible for non-covered services and expenses. I also authorize Princeton Dental, P.A. to release any information required.

Signature of Patient or Legal Guardian_____