INSURANCE REGISTRATION

It is the policy of our office to automatically file dental insurance claims WHEN PROPER INFORMATION IS PROVIDED US. Please understand that we are only able to ESTIMATE your insurance benefits and that any amount NOT PAID BY YOUR INSURANCE COMPANY will be your personal responsibility.

PLEASE TELL US ABOUT YOUR PRIMARY POLICY

EMPLOYEE NAME ____________________ EMPLOYEE BIRTHDATE ____________________

EMPLOYEE SOCIAL SECURITY # ____________________

EMPLOYEE ADDRESS (if different than patient address) ____________________

NAME OF EMPLOYER ____________________

NAME OF INSURANCE COMPANY ____________________ GROUP POL. # ____________________

Insurance company address: ____________________

Insurance company verification phone # (   ) ____________________

PLEASE TELL US ABOUT YOUR SECONDARY POLICY

EMPLOYEE NAME ____________________ EMPLOYEE BIRTHDATE ____________________

EMPLOYEE SOCIAL SECURITY # ____________________

NAME OF EMPLOYER ____________________

NAME OF INSURANCE COMPANY ____________________ GROUP POL. # ____________________

Insurance company address: ____________________

Insurance company verification phone # (   ) ____________________

ASSIGNMENT OF BENEFIT AUTHORIZATION

I hereby authorize release of information of my dental records to my insurance company.

SIGNED (patient) (parent) ____________________ DATE ____________________

I hereby authorize direct reimbursement to H. Darrell Hamon, D.D.S. for all forthcoming claims.

SIGNED (employee) for PRIMARY ____________________ DATE ____________________

I hereby authorize direct reimbursement to H. Darrell Hamon, D.D.S. for all forthcoming claims.

SIGNED (employee) SECONDARY ____________________ DATE ____________________

SIGNED H. Darrell Hamon, DDS, MAGD ____________________ DATE ____________________