CHESTNUT DENTAL
YOUR SMILE'S IN GREAT HANDS

# DENTAL INFORMATION FORM

It is very important all information regarding your dental insurance is accurate and up-to-date so that we may assist you in obtaining full insurance benefits.

**DENTAL INSURANCE CARRIER:** Primary____ Secondary ____ Change ____
**Subscriber's Name:** _____
Address: _____
City: _____ State: _____ Zip: _____ Home #: _____
Business #:_____ Cell #:_____
Spouse's #:_____ Email address:_____
**Subscriber ID#:**_____ **Subscriber DOB:**_____ Male / Female
**SS#:**_____**Group#:**_____ **Effective Date:**_____

**Employer Name:**_____

**DENTAL INSURANCE PLAN NAME:** _____
Address:_____ City:_____ State: ____ Zip: _____

**Patient Name(s)**:_____ Date: _____

**SECONDARY INSURANCE:** Are Any Patients Covered Under Any Other Dental Plan? Yes___ No___

**Subscriber's Name:** _____
**Subscriber ID#:** _____ **Subscriber DOB**: _____
**SS#**: _____ **Group#**:_____ **Effective Date**: _____

**Employer Name:** _____

**DENTAL INSURANCE PLAN NAME:** _____
Address: _____ City:_____ State:_____ Zip:_____
**Patient Name(s)** :_____ Date:_____

My signature below shall serve as my informed consent to perform all recommended treatment for myself and/or dependents. It shall also serve as authorization to assign any benefits to my provider. I understand that estimated co-payments are estimates only, subject to policy maximums, limitations, and coordination of benefit rules in effect at the time of service. Any unpaid portion shall be my responsibility.

**Please note: If your insurance company does not pay your claim within 60 days, you will become responsible for the charges.**

**Insurance companies have filing limits (the time between the date of service and the date the insurance company receives the claim). Claims presented beyond that time will not be paid by your insurance company and will become your responsibility.**

Signature: _____ Date: _____