PRESERVE PARKWAY DENTAL

INSURANCE AGREEMENT

We are happy to submit insurance claims on your behalf in order for you to receive insurance benefits. To do this accurately, we will need the following information insurance information from you.

Please complete:

Subscriber's First and Last name:_____

Subscriber's Date of Birth: _____

Subscriber's Employer:_____

Subscriber's ID or SSN:_____

Group Number:_____

Name of Insurance Company:_____

Phone Number of Insurance Company:_____

Address of Insurance Company_____

Please list additional family member's names and dates of birth covered under this policy:

Name: _____ DOB:_____

Name: _____ DOB: _____

Name:_____DOB: _____

Please check with your insurance company regarding your coverage and dental benefits. It is your responsibility to know and understand your coverage. Our treatment recommendations are based on what we feel is the best treatment possible for you, and is **not based on your insurance benefits. Some insurance carriers require you to see a specific Dentist in order to receive benefits. Please check with your insurance company to make sure you able to receive benefits at our practice.*

I have read and understand the above information. I have accurately given you my insurance information. I agree that I am responsible for all charges not covered by my insurance.

Patient Name:_____

Patient Signature: _____ Date:_____