

INSURANCE INFORMATION

NAME _____

PRIMARY DENTAL INSURANCE CARRIER _____

GROUP NUMBER _____

EMPLOYEE'S NAME _____ BIRTH DATE _____

EMPLOYEE'S SOCIAL SECURITY NO. _____

PATIENT'S RELATIONSHIP TO EMPLOYEE _____

EMPLOYER _____ PHONE _____

ADDRESS _____

CITY/STATE/ZIP _____

SECONDARY DENTAL INSURANCE CARRIER _____

GROUP NUMBER _____

EMPLOYEE'S NAME _____ BIRTH DATE _____

EMPLOYEE'S SOCIAL SECURITY NO. _____

PATIENT'S RELATIONSHIP TO EMPLOYEE _____

EMPLOYER _____

PHONE _____

ADDRESS _____

CITY/STATE/ZIP _____

Coordination Of Benefits Information:

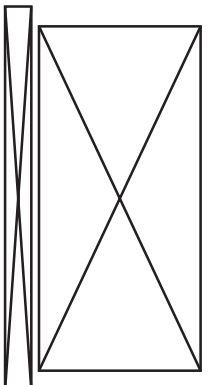
If a patient is eligible for coverage under two or more dental care programs, a claim must be filed in the correct order with each carrier. To determine the order of benefit payment, the plan covering the patient as the employee has the primary responsibility before the plan covering the patient as a dependent. If patient is a dependent child, primary coverage is with the parent whose birthday comes first in the year.

PLEASE NOTE:

We will gladly file your insurance as a courtesy to you, but you are responsible for the payment of any charges not covered by your dental insurance. We ask that your portion of the charges be paid at the time of the appointment unless prior arrangements have been made with the Financial Coordinator. The Undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of self and/or dependents. It is further expressly agreed and acknowledged that the signature authorizes the dentist to submit claims for benefits, for services rendered or to be rendered without obtaining signatures on each and every claim to be submitted. The undersigned will be bound by this signature as though he/she had personally signed the particular claim. The undersigned also understands that a finance charge of 1.25% will be added to accounts 30 days or older.

SIGNED _____

DATE _____



88 Charles Street
Deadwood, South Dakota 57732
Telephone (605) 578-3810 • Fax (605) 578-3812

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

– You may refuse to sign this acknowledgment –

I, _____, have received a copy of this
office's Notice of Privacy Practices.

Please print name _____

Signature _____

Date _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (please specify) _____

