Dover Dental Group

3281 N High St.
Columbus, Oh 43202
(614) 263-1212

INSURANCE INFORMATION

Date_____
Patient Name_____
SSN # _____ Date of Birth _____
Sex: Male___ Female___
Marital Status: Single___ Married___
Student: Yes ___ No ___
If yes, where do you attend school? _____
Do you have physical or mental disabilities? Yes ___ No ___

Insurance Company _____
Policyholder Name _____Date of Birth_____
Policyholder Social Security Number _____
Policyholder Employer _____
Employer Address _____
_____
Employer Phone Number _____
Employment Status: Part time___ Full time___
Relationship to policyholder: Self___ Spouse___ Child___
Other___ please specify _____

Emergency Contact (*Not living with you*):
Name _____
Relation _____
Phone Number _____

As a courtesy to you, our office will bill your insurance company for services rendered. The patient is responsible for any deductible or co pay that applies. The deductible or co pay is due at the time services are rendered. Patient is also responsible for any portion that is not paid by the insurance company. Returned checks will be subject to an additional $30.00 fee, and patient is responsible for all costs including cost of collection and attorney fees for any unpaid amount.

I understand that ultimately I am responsible for making sure that my bill is paid within 45 days from the time of service, regardless of insurance coverage.

Signature of responsible party _____ Date _____