The Dental Group
5478 N. Hamilton Rd.
Columbus, Oh 43230
(614) 939-8338

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 __________