Insurance Information

Primary dental Insurance:

Insured/Policy Holder:_____Birthdate:_____SS#/ID#_____

Insured Employer:_____ Relationship to Insured:_____

Ins. Company:_____ Ins. Address:_____

City:_____ State:_____ Zip:_____ Ins Phone:_____

Group #:_____

Secondary Dental Insurance:

Insured/Policy Holder:_____Birthdate:_____SS#/ID#_____

Insured Employer:_____ Relationship to Insured:_____

Ins. Company:_____ Ins. Address:_____

City:_____ State:_____ Zip:_____ Ins Phone:_____

Group #:_____

Consent

I, the undersigned, hereby authorize the Doctor to take radiographs, or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the Doctor employ any such assistant as he/she deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others may request my records. I certify that the above insurance information, if applicable, is correct and in force. I am aware that it is my responsibility to read and understand my own dental insurance policy, including benefits, limitations and exclusions. I understand that filing of insurance claims is my responsibility and may be provided as a service to me by Tigard Family Dental, PC, and that any agreement for dental coverage is between my insurance company and myself. I understand that an estimate portion is due at the time of service and is estimated according to expected coverage, which may not be disclosed nor guaranteed by my insurance company. I understand my portion may be more if my insurance company does not pay the anticipated amount. I also understand that services are rendered independent of insurance reimbursement.

I understand that I am personally responsible for payment of all fees for dental services provided in this office form or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins. I agree that credit bureau reports may be obtained, where appropriate. I will notify Tigard Family Dental, PC if there is a change in the family relationship on the account (divorce, separation, adoption).

__X_____

Signature Date Relationship to Patient