***INSURANCE FORM*:**
INSURANCE REFERENCE SHEET

*Our office gladly files insurance for all patients. Please provide us with proper dental insurance information to verify* ***estimated*** *benefits, annual maximums, and deductibles. We ask that any questions you have regarding your particular plan be directed to your employer or by contacting your insurance company.* ***All estimated non-covered amounts are expected at the time services are rendered.*** *We will follow up on outstanding (unpaid) claims; however it is the insured' s responsibility to contact the insurance company if a claim has been filed and no benefits received after* ***60*** *days at which point the balance becomes your responsibility. If you are not able to provide our office with complete insurance information, we will not be able to file your insurance and will ask that payment be paid in full. Thank You*

**Primary Dental Insurance**

1. Patient name: ______________________________________________________________________
2. D.O.B. _____/_____/_____

3. Cardholder Name:___________________________________________________________________
   (AS IT APPEARS ON YOUR DENTAL INSURANCE CARD)

4. Cardholder SS#: __________-___________-___________
5. cardholder D.O.B. _________/________/_______

6. Address and phone # for cardholder if different from patient:

   Street Address:
   ________________________________________________________________________________

   City____________________________________ State______________ Zip Code_____________
   Home Phone __________________

4. Employer Name:__________________________________________________________________________
5. Insurance Company Name:____________________________________________________
6. Group # __________________________

7. Plan name or number: ________________________________________________________
   Phone #:__________________________

8. Claims Address: ____________________________________________City:_________________
   ST: ___________Zip___________

   *I authorize the release of any information relating to treatment. I understand that I am responsible for all costs of dental treatment regardless of my dental coverage.*

   *Signature:* ________________________________________________________________
   *Date:* _______________________________________

   *I hereby authorize payment of the insurance benefits to be made directly to Barbara J. Utermark, DMD.*

   *Signature:* _________________________________________________________________
   *Date:* _______________________________________