Insurance Information

PRIMARY INSURANCE COVERAGE

Dental Insurance Company:____

Address:____

City, State, Zip:____

Subscriber #:_________________________Group #:________________________

Employer:____

Employee Name:___________________________Date of Birth:______________

SECONDARY INSURANCE COVERAGE

Dental Insurance Company:____

Address:____

City, State, Zip:____

Subscriber #:_________________________Group #:________________________

Employer:____

Employee Name:___________________________Date of Birth:______________

NOTE: As a service for our patients we will file your insurance. Our computers will ***estimate*** how much your insurance will cover for each procedure. Please remember that this is only an estimate, and if the actual amount covered by insurance is different you will be responsible for that amount. Deductables, copays and the remaining amount (after the estimated insurance coverage has been calculated) is due at time of service.

AUTHORIZATION: I hereby give Larry G. Causey DDS, PA, permission to file computer generated insurance forms without policy holder's signature for dental treatment received.

Signature:____ Date:____________________

(Parent/Guardian, if patient is a minor)

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