IVERSON & BURTON DENTAL
DENTAL INSURANCE INFORMATION

PATIENT NAME_____BIRTHDAY_____

PRIMARY INSURANCE INFORMATION

NAME OF INSURED_____RELATIONSHIP TO PATIENT_____

BIRTHDATE OF INSURED_____SS# (REQUIRED)_____

ADDRESS OF INSURED_____CITY, STATE, ZIP_____

MAILING ADDRESS IF DIFFERENT_____CITY, STATE, ZIP_____

HOME PHONE OF INSURED_____CELL PHONE OF INSURED_____

EMPLOYER OF INSURED_____WORK PHONE OF INSURED_____

EMPLOYER OF INSURED ADDRESS_____CITY, STATE, ZIP_____

INSURANCE COMPANY_____INSURANCE COMPANY PHONE #_____

INSURANCE COMPANY ADDRESS_____CITY, STATE, ZIP_____

ID #_____EFFECTIVE DATE_____GROUP #_____

SECONDARY INSURANCE INFORMATION

NAME OF INSURED_____RELATIONSHIP TO PATIENT_____

BIRTHDATE OF INSURED_____SS# (REQUIRED)_____

ADDRESS OF INSURED_____CITY, STATE, ZIP_____

MAILING ADDRESS IF DIFFERENT_____CITY, STATE, ZIP_____

HOME PHONE OF INSURED_____CELL PHONE OF INSURED_____

EMPLOYER OF INSURED_____WORK PHONE OF INSURED_____

EMPLOYER OF INSURED ADDRESS_____CITY, STATE, ZIP_____

INSURANCE COMPANY_____INSURANCE COMPANY PHONE #_____

INSURANCE COMPANY ADDRESS_____CITY, STATE, ZIP_____

ID #_____EFFECTIVE DATE_____GROUP #_____

If you have dental insurance, we are happy to process your claims for you. Your estimated insurance co-pay/co-insurance is due the day of the appointment unless other arrangements are made. **I understand that my dental insurance is a contract between the insurance company and myself, not between the insurance company and the dentist. I have read my policy and understand my dental coverage. I understand that my dental insurance policy may not cover all fees according to the estimate provided by Iverson and Burton Dental. I understand I am responsible to pay all fees not covered by my insurance.** I, hereby, authorize my dental insurance company to make payment directly to Iverson & Burton Dental, LLC. I grant the right to Iverson & Burton Dental, LLC to release dental and medical histories and other information about dental treatment to third party payers (the insurance). I understand that I will be charged for all dental treatment. Any payments received by Iverson & Burton Dental, LLC from my insurance coverage will be credited to my dental account or refunded to me if such payment results in a credit balance on the account.

_____DATE_____

SIGNATURE OF INSURED OR ACCOUNT RESPONSIBLE PARTY