Alliance Oral and Maxillofacial Surgery

Patient Name: _____

Please complete your insurance information below. If you are a self pay patient and no insurance will be processed for your visit, check the self pay option below and sign this document.
Thank You!

☐ **SELF PAY (No Insurance)**

☐ **DENTAL INSURANCE INFORMATION**
Primary Holder: Patient / Spouse / Parent (CIRCLE ONE)
Name of Primary Holder: _____
Birthday of Primary Holder: _____
SS# of Primary Holder: _____
Employer of Primary Holder: _____
Insurance Company Name: _____
Insurance Company Phone #: _____
Subscriber ID #: _____
Group #: _____

☐ **MEDICAL INSURANCE INFORMATION**
Primary Holder: Patient / Spouse / Parent (CIRCLE ONE)
Name of Primary Holder: _____
Birthday of Primary Holder: _____
SS# of Primary Holder: _____
Employer of Primary Holder: _____
Insurance Company Name: _____
Insurance Company Phone #: _____
Subscriber ID #: _____
Group #: _____

PLEASE READ THIS CAREFULLY

You are entering into a relationship with the doctor, in which the doctor agrees to treat the patient and the patient agrees to pay the doctor's fee for treatment. As a courtesy we will assist you by filing your claim to your primary insurance company for all office visits. On the day of surgery you will pay your estimated portion of the total fee. Keep in mind, this amount is based on what your insurance company has told us regarding what they will pay for the surgery.

Please remember, these are only estimates and are not always accurate. If we are misquoted by your insurance company, we are not responsible for their mistake and you will be billed based on your insurance company explanation of benefits. A pre-treatment estimate can be sent by our office to your insurance company and is the most accurate estimate that can be obtained. If you would like to wait on a pre-treatment estimate, please inform our office. Once insurance has paid, you will be billed or refunded accordingly.

For the purpose of filing claims/Insurance verification, I authorize the release of any information and I assign benefits to the doctor. By signing below, I agree to the above terms of financial responsibility.

_____ _____
Signature of Patient or Authorized Representative Date