Langdon Crossing Dental

PRE-ESTIMATES ARE NOT A GUARANTEE OF PAYMENT. BENEFITS ARE CALCULATED BASED ON CURRENT AVAILABLE BENEFITS AND PATIENT ELIGIBILITY. ESTIMATES ARE SUBJECT TO MODIFICATION BASED ON ELIBILITY, COORDINATION OF BENEFITS, THE CONTRACT ALLOWANCE, AND THE BENEFIT PLAN IN EFFECT AT THE TIME SERVICES ARE COMPLETED.

INSURED PATIENT INFORMATION

Name of patient _____

Name of policy holder _____

Date of birth of policy holder _____

Insurance Company _____ **Policy No.**_____

Subscriber ID number _____

Place of employment _____

Relationship of patient to policyholder Self _____ Dependant _____ Spouse _____

Are you claiming from more than one insurance company No _____ Yes_____?
If yes, complete the following section:

SECONDARY INSURANCE INFORMATION

Name of policy holder _____

Date of birth _____

Insurance Company _____ **Policy No.** _____

Subscriber ID number_____

Place of employment _____

Relationship of patient to policyholder: Dependant _____ Spouse _____

AUTHORIZED CONSENT TO RELEASE INFORMATION

1 authorize release, to my dental benefits plan administrator, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described, to the named dentist, Dr. N. Selvanovskiy.

_____ _____

Signature of patient, parent or guardian Date