

**Martin Kids Dental Health Team
Insurance Information**

The following information regarding your insurance coverage is necessary to process your insurance claim. Please complete the following to expedite your claim and to insure that you receive the maximum benefit available.

Please remember your insurance is a contract between you and your insurance provider. You are responsible for understanding your benefits deductibles, limitation and exclusions.

Patient's Name: _____ **DOB:** _____

Name of Subscriber: _____	DOB: _____
Address: _____	Zip: _____
Telephone Number: _____	SS#: _____

Insurance Company: _____	
Address: _____	
Telephone Number: _____	Member/Subscriber Id: _____
Plan or Group Number: _____	
How long have you had this policy: _____	
Does your policy have orthodontic coverage: _____	

Name of Employer/Company: _____
Address: _____
Telephone Number: _____

By signing below I authorize release of any information pertaining to treatment and authorize payment of dental benefits directly to Martin Kids Dental Health Team. I also acknowledging that I am responsible for understanding my dental insurance's, policies, benefits, deductibles, limitations and exclusions. I acknowledge any estimate provided by Martin Kids Dental is an estimate and not a final bill.

Signature: _____ **Date:** _____

Print Name: _____ **Relationship to Patient:** _____

Office use ONLY: