

**Robert J. Farbman, D.D.S., P.A.**  
**PATIENT DENTAL INSURANCE**  
Please complete your insurance information below.

Patient Information		
Patient Name: _____		
Last	First	MI
Address: _____		
Street	Apartment #	
_____		
City	State	Zip Code

Primary Dental Insurance Information		
Insurance Company Name: _____		Phone: _____
Address: _____		
Street		
_____		
City	State	Zip Code
Insured's Name: _____		Group / Policy No: _____
Insured's Soc. Sec. / ID No. _____		Insured's Date of Birth: _____
Name of Insured's Employer: _____		

Secondary Dental Insurance Information		
Insurance Company Name: _____		Phone: _____
Address: _____		
Street		
_____		
City	State	Zip Code
Insured's Name: _____		Group / Policy No: _____
Insured's Soc. Sec. / ID No. _____		Insured's Date of Birth: _____
Name of Insured's Employer: _____		

Consent for Services & Signature on File		
<p>As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. I understand that payment for treatment is due in full at the time services are performed unless other financial arrangements have been made in advance.</p> <p>Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental insurance. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account.</p> <p>I understand that my dental insurance benefits are based upon a contract made between myself or my employer and my insurance carrier. I understand that this office is not part of this contract, and that all fees not covered by my insurance carrier for any reason are my responsibility.</p> <p>I authorize the use of this form on all of my insurance submissions. I authorize the release of information to all my insurance carriers. I understand that I am responsible for my bill. I authorize payment directly to my doctor.</p> <p>I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. I grant permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form. I certify that I have read and understand the above conditions of treatment and payment and agree to their content.</p>		
Signature of patient, parent, or guardian _____	Print Name _____	Date _____