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

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.

Patients who carry dental insurance understand that all dental services furnished are changed 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.

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.

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.

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.

_____ _____ _____
Signature of patient, parent, or guardian **Print Name** **Date**