Dat Complete Dentistry

43 S York Rd
Hatboro, PA 19040
www.datdentist.com

INSURANCE INFORMATION

Person responsible for account:
Last:_____ First: _____
Date of Birth: _____ SSN: _____
Address: _____
City: _____ State: _____ Zip: _____

Insurance Company: _____
Subscriber: _____ Date of Birth: _____
Subscriber Number: _____ Group Number: _____
Name of Employer/Company on Card: _____

SECONDARY INSURANCE

Insurance Company:_____
Subscriber: _____ Date of Birth: _____
Subscriber Number: _____ Group Number: _____
Name of Employer/Company on Card: _____

ASSIGNMENT AND RELEASE

I the undersigned, hereby authorize and direct my insurance carrier to pay directly to Dat Complete Dentistry all insurance benefits, if any, due to me under my insurance plan. I further agree to pay the balance of the charges not paid by my insurance. Any balance that is not paid within 45 days will also be my responsibility. I hereby authorize the release of any information necessary to secure payment of benefits. I also authorize the use of this signature on all insurance submissions. If the patient is a minor, I agree a legal guardian gives consent for treatment for this and future service rendered.

Responsible Person/Patient Signature: _____
Date:_____