

JAMES R. SANDLIN, DDS
Dental Health and Rehabilitation
INSURANCE INFORMATION

TODAY'S DATE: ___/___/___

PRIMARY COVERAGE

PATIENT NAME: _____

INSURED'S NAME: _____

ADDRESS: _____

CITY, STATE, ZIP CODE: _____

INSURED'S SOCIAL SECURITY NUMBER: _____ INSURED'S DATE OF BIRTH: ___/___/___

PATIENT'S RELATIONSHIP TO INSURED: (CIRCLE ONE) SELF / SPOUSE / CHILD / OTHER

EMPLOYER NAME: _____

GROUP ID / NUMBER: _____

EMPLOYER ADDRESS: _____

CITY, STATE, ZIP CODE: _____

EMPLOYER PHONE NUMBER: _____

SEND DENTAL CLAIMS TO:

INSURANCE COMPANY NAME: _____

ADDRESS: _____

CITY, STATE, ZIP CODE: _____

PHONE NUMBER: _____

I HEREBY GIVE PERMISSION TO RELEASE INFORMATION REGARDING MY TREATMENT. I HEREBY ASSIGN ANY BENEFITS AVAILABLE FOR MY TREATMENT TO BE PAID DIRECTLY TO DR. SANDLIN.

PATIENT OR GUARDIAN SIGN HERE

INSURED SIGN HERE

INSURANCE FILING IS PROVIDED AS A COURTESY FOR OUR PATIENTS. IN ORDER FOR US TO HELP YOU FILE YOUR INSURANCE, WE MUST HAVE YOUR FORM COMPLETED WITH ALL INFORMATION INCLUDING THE CORRECT MAILING ADDRESS FOR THE CLAIM. NOTE THAT WE ARE NOT ABLE TO FILE FOR ANY SECONDARY COVERAGE.

WE ARE HAPPY TO ACCEPT ASSIGNMENT ON ANY BENEFIT YOU MAY HAVE, BUT YOU MUST ACCEPT RESPONSIBILITY FOR YOUR ACCOUNT BALANCE IN FULL IF YOUR CLAIM IS NOT PAID WITHIN 45 DAYS. WE DO NOT PARTICIPATE IN ANY HMO, DMO, OR PPO PROGRAMS AND HAVE NO AGREEMENTS WITH ANY INSURANCE CARRIERS. THEREFORE, YOU ARE RESPONSIBLE FOR ANY SHORTFALL IN YOUR COVERAGE AND MUST AGREE TO PAY ANY AMOUNT THAT YOUR INSURANCE CARRIER FAILS TO RELEASE.

I UNDERSTAND AND AGREE TO THE ABOVE CONDITIONS.

SIGNATURE

DATE