# EASTSIDE DENTAL CLINIC

## PATIENT INSURANCE REGISTRATION FORM

**FULL NAME OF PATIENT**_____ **BIRTHDATE**_____

*Dental health is an excellent investment in an individual's medical and psychological well being. Dental insurance plans are designed to share in your dental care costs. Your dental benefit plan is a contract between your employer, plan sponsor, insurance broker and/or third-party administrator. Your dental plan may not allow benefits for all treatment options, even when your dentist determines that another treatment will be in your best interest. Please be familiar with your insurance policy as many have pre-existing conditions, waiting periods or least-costly alternative provisions.*

*Insurance coverage is only an estimation. We require payment for any deductible and/or patient co-portions due at each visit.* ***We will bill your insurance as a courtesy to you.*** *The patient or guarantor is responsible for any balance not covered by insurance. If insurance has not paid within 60 days, the bill is due in full. We are always happy to help obtain information to assist patients with insurance.*

---

**PRIMARY INSURANCE COMPANY**_____ GROUP #_____

INSURED PERSON'S NAME_____ BIRTHDATE_____

SOCIAL SECURITY #_____ INSURANCE ID #_____

INSURANCE ADDRESS_____ TELEPHONE #_____

EMPLOYER OR UNION_____ RELATIONSHIP TO PATIENT_____

☐ PATIENT A FULL-TIME STUDENT? _____ SCHOOL:_____

---

**SECONDARY INSURANCE COMPANY**_____ GROUP #_____

INSURED PERSON'S NAME_____ BIRTHDATE_____

SOCIAL SECURITY #_____ INSURANCE ID #_____

INSURANCE ADDRESS_____ TELEPHONE #_____

EMPLOYER OR UNION_____ RELATIONSHIP TO PATIENT_____

---

**INSURANCE AUTHORIZATION-SIGNATURE ON FILE**

*I hereby authorize my health care provider to affix my name to all insurance submissions, documents, and/or information requested by my insurance company(s) relating to any and all health benefits due to me and my dependents.*

*I also authorize payment of healthcare benefits otherwise payable to me, directly to my doctor as listed above. I agree to be held responsible for all charges and services not paid by my insurance company. (A copy of this assignment is as valid as the original).*

_____

**Signature** ☐ YES ☐ NO **(Patient of Legal Age, Insured or Parent/Guardian)** **Date**