



whitmiredmd.com

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PATIENT INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE CARRIER:

Insured's Name _____ SS # _____ DOB ___/___/___
Employer _____ Employers Address & Phone _____
Insurance Carrier _____ Group # _____ Phone _____
Insurance Carrier's Address _____

SECONDARY DENTAL INSURANCE CARRIER:

Insured's name _____ SS # _____ DOB ___/___/___
Employer _____ Employer's Address & Phone _____
Insurance Carrier _____ Group # _____ Phone _____
Insurance Carrier's Address _____

AUTHORIZATION TO RELEASE MEDICAL /DENTAL INFORMATION:

I authorize the release of any medical/ dental information necessary to process my insurance claim(s). I also certify that all insurance information given to Anna F. Whitmire, DMD is correct and complete. A photocopy of my signature shall be valid as original.

Patient's signature _____
Insured's signature _____

AUTHORIZATION TO PAY ANNA F. WHITMIRE, DMD / GENERAL & COSMETIC DENTISTRY

I hereby authorize my insurance company to pay by check made out to and mailed directly to : Anna F. Whitmire, DMD the expense benefits allowable and otherwise payable to me under my current insurance policy, as payment towards the total charges for professional services rendered. This payment shall not exceed the total charges for the charges performed by Anna F. Whitmire, DMD. I agree to be responsible for my bill and any portion that the insurance company does not pay. I will pay any balance remaining within 30 days . I understand that Anna F. Whitmire, DMD is not part of any dental plans. I understand that the staff of Anna F. Whitmire, DMD cannot guarantee how much, or even if, my insurance company will pay on a claim, since the insurance company has the contract with me and not with Anna F. Whitmire, DMD and insurance plans vary widely in their allowable fees and covered charges. I further agree to immediately sign over the Anna F. Whitmire, DMD without cashing, any insurance payments sent to me. A photocopy of my signature shall be valid as original. If my insurance does not pay within 45 days of claim submission, I will be responsible for the payment and will follow up with my insurance.

Patient's signature _____
Insured's signature _____