PEDIATRIC DENTAL ASSOCIATES, LLC

Insurance and Consent

Name of patient: ____Date of birth: ________________

* **MEDICAID/DENALI KID CARE ID#:** ___________________________

***PRIMARY INSURANCE:**

Policy Holder Name: __________________________________Relationship to patient:_______________

ID ______ _____________________________________Date of birth: ______________________
Alpha prefix

Employer: ____ Group # _______________________

Insurance Carrier: ______________________________ Ph# ________________Effective Date_________

Claim Mailing Address: ____

Policy Holder's phone number & address: Home (_____)______-__________ Cell (_____)_____-__________

____ City _________________ State _____ Zip __________

***SECONDARY INSURANCE:**

Policy Holder Name: __________________________________Relationship to patient:_______________

ID ______ _____________________________________Date of birth: ______________________
Alpha prefix

Employer: ____ Group # _______________________

Insurance Carrier: ______________________________ Ph# ________________Effective Date_________

Claim Mailing Address: ____

Policy Holder's phone number & address: Home (_____)______-__________ Cell (_____)_____-__________

____ City _________________ State _____ Zip __________

**Name of person(s) patient resides with____

****Are there any court orders which would supersede the "birthday rule"?** **Yes / No** (if yes, documentation must be provided)

CONSENT & ASSIGNMENT OF BENEFITS:

- I assign payment of all insurance benefits otherwise payable to me, directly to Pediatric Dental Associates LLC.
- I understand that I am responsible for payment of services when rendered and also responsible for paying any co-payment and deductible that my insurance does not cover at each visit. I hereby authorize Pediatric Dental Associates LLC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. I authorize Pediatric Dental Associates LLC to contact myself at any phone number, email address, or cell phone number I have provided on this Registration or given verbally.
- I will inform Pediatric Dental Associates LLC of any change in my child's health and/or medications, family information, financial responsibly, or insurance coverage. I will not hold Pediatric Dental Associates LLC or any of its Doctor's staff members responsible for any errors or omissions that I may have made in completion of this form.
- I agree to comply with this office's Financial and Appointment Policy and am aware a copy is available upon my request.

_____________________________________ ___________________________________ ____/______/______
Responsible Party's name Responsible Party's signature Date