

INSURANCE INFORMATION FORM

Our office currently uses the CDAnet electronic system. This system allows us to process your insurance claims more quickly. Please take a few moments to complete the information below and sign the authorization at the bottom. Please ensure that you complete all the sections for faster processing.

It continues to be our office policy that you (our patient) must take care of all professional fees at the time of or in advance of your appointment. In addition, all laboratory fees (if applicable) are due at the time of or in advance of the bonding appointment.

CDAnet PATIENT INFORMATION FORM

A. INSURED PATIENT INFORMATION:

1. Name of Patient: _____

2. Name of Policy Holder: _____

3. Policy Holder's Date of Birth: _____

4. Insurance Company: _____ Policy #: _____

5. Certificate/Subscriber ID Number: _____

6. Place of Employment: _____

7. Relationship of patient to Policy Holder: Self: _____ Spouse: _____ Dependent/Child: _____ Other: _____

8. Are you claiming from one or more insurance company? Yes: _____ No: _____

If yes, complete the following section:

B. SECONDARY INSURANCE INFORMATION:

1. Name of Policy Holder: _____

2. Policy Holder's Date of Birth: _____

3. Insurance Company: _____ Policy #: _____

4. Certificate Number: _____

5. Place of Employment: _____

6. Relationship of patient to Policy Holder: Self: _____ Spouse: _____ Dependent/Child: _____ Other: _____

AUTHORIZED CONSENT TO RELEASE INFORMATION

I authorize release, to my dental benefit plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist.

I hereby authorize release of information related to manual predetermination(s) & claim submission(s). (i.e. Patient information, photos, x-rays, models, etc.)

This authorization shall continue in effect until the undersigned revokes the same.

Signature of patient or parent/guardian

Date