DENTISTRY ON ROSSLAND
575 Thornton Rd N, Oshawa, ON L1J 8L5

289.971.1587

PATIENT INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE CARRIER:

Insured's Name _____ SI# _____ Date of Birth_____

Insured's Employer_____ Employer's Address & Phone #_____

Insurance Carrier_____Group#_____Phone#_____

Insurance Carrier's Address_____

SECONDARY DENTAL INSURANCE CARRIER:

Insured's Name_____ SI# _____Date of Birth_____

Insured's 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 **Dentistry on Rossland** is correct and complete. A photocopy of my signature shall be valid as original.

Patient's Signature_____

Insured's Signature_____

AUTHORIZATION TO PAY DENTISTRY ON ROSSLAND

I hereby authorize my insurance company to pay by check made out to and mailed directly to: **Dentistry on Rossland**, hereafter known as **Faina Seagal** 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 services performed by Faina Seagal. 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 Faina Seagal is not part of any dental plans. I understand that the staff of Faina Seagal **cannot guarantee how much, or even if, my insurance company will pay** on a claim, since the insurance company has a contract with me and not with Faina Seagal and insurance plans vary widely in their allowable fees and covered charges. I further agree to immediately sign over to the Faina Seagal without cashing, any insurance payments sent to me. If I should cash and hold these funds, I agree to pay the Faina Seagal a **20% late fee** for the amount of any funds I may take. 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: _____

Print

WE FILE PRIMARY INSURANCE AS A COURTESY. THE PATIENT MUST FILE AND FOLLOW-UP WITH THE SECONDARY INSURANCE. WE WILL PROVIDE YOU WITH ALL THE NECESSARY PAPERWORK ON OUR PART TO FILE FOR YOUR BENEFITS.