Dental Insurance Information

Primary Insurance Information

Name of Insured: _____
Relationship to Patient: o Self o Spouse o Child o Other
Insured Soc. Sec.: _____
Insured Birth Date: _____

Subscriber ID#: _____ **Group ID#:** _____

Employer: _____
Address of Policy Holder: _____
Address Line 2: _____
City, State, Zip:_____

Ins. Company: _____
Address: _____
City, State, Zip:_____
Ins. Company Phone #:_____

Secondary Insurance Information

Name of Insured: _____
Relationship to Patient: o Self o Spouse o Child o Other
Insured Soc. Sec.: _____
Insured Birth Date: _____

Subscriber ID#: _____ **Group ID#:** _____

Employer: _____
Address of Policy Holder: _____
Address Line 2: _____
City, State, Zip:_____

Ins. Company: _____
Address: _____
City, State, Zip:_____
Ins. Company Phone #:_____

Assignment of Benefits
I hereby assign all dental benefits, to which I am entitled. I hereby authorize and direct my insurance carrier(s) to issue payment check(s) directly to Dr. Joshua Robbins and associates (Joshua M. Robbins, DMD, PLLC DBA Family Dental of Westborough) rendered to myself and/or my dependents regardless of my insurance benefits if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information
I hereby authorize Dr. Robbins and associates to: (1) release any information necessary to insurance carriers regarding my treatment; (2) process insurance claims generated in the course of examination or treatment; (3) allow my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing. I have requested dental services from Dr. Robbins and associates on behalf of myself and/or my dependents and understand that by making this request, I become fully responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred that my insurance does not cover, upon presentation of the appropriates statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature_____ Date_____