



"Putting your child's dental health on the right track."

DENTAL INSURANCE INFORMATION

Primary Insurance Co.

Primary person on Policy?

Date of Birth

Employer

Ins. Co. Phone:

I.D. #

Group #

Secondary Ins. Co.

Primary person on Policy?

Date of Birth

Employer

Ins. Co. Phone:

I.D. #

Group #

MEDICAL / DENTAL RELEASE STATEMENT

I give my consent for the doctors of Black Hills Pediatric Dentistry to do a complete and thorough examination on the patient previously named, including any diagnostic radiographs needed. To the best of my knowledge, the information that I have given is correct and I understand that it will be held in the strictest confidence. Furthermore, I understand that it is my responsibility to inform Black Hills Pediatric Dentistry of any future changes to my child's medical status. As the parent or legal guardian of the previously named patient, I do hereby grant Black Hills Pediatric Dentistry and its staff permission to perform any needed treatment(s). I also understand that all necessary treatment will be explained prior to commencement and that I am responsible for payment in full at the time of service, unless prior arrangements have been approved. *Initial*

REQUIREMENT FOR FILING INSURANCE CLAIMS To expedite the filing of my dental insurance claims, I do hereby authorize the release of confidential information to my dental insurance agency and understand that I am personally responsible for any balance remaining after the insurance payment has been received. I am also fully responsible if my insurance policy fails to pay, for any reason, within thirty (30) days of treatment. I hereby authorize payment of insurance benefits directly to Black Hills Pediatric Dentistry or the dentist that performs treatment on my child. *(Please Note: Blue Cross/Blue Shield and Dakotacare are handled differently as they have elected to only send the benefit checks directly to the policyholder. Since these two insurance carriers do not allow assignment of benefits, we have no choice but to use a different policy when assisting our patients who are covered by BC/BS and Dakotacare. Please read our Blue Cross/Blue Shield and Dakotacare letter.)* Furthermore, in the event of payment default for services previously rendered, I also agree to pay all reasonable collection and/or legal fees incurred in an attempt to collect on this amount.

Initial

Parent or Legal Guardian Signature

Date

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