Insurance Information and Consent

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Social Security #: _____ Birth Date: _____

Insurance Information

(Please present your insurance card and picture identification to the receptionist)

Insurance Plan Name: _____

ID #: _____ Group #: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Name of Insured (if other than patient): _____
Last First MI

Insured's Birth Date: _____

Insured's Address: _____
Street City State Zip Code

Acknowledgement and Consent

The goal of Eli Abbo, DMD,PA, is to provide patients with the best dental care. If a patient has dental insurance, the office staff will assist him/her in utilizing the benefits provided under the policy. In order to achieve these goals, it is important that the patient/responsible party understand and agree to the following conditions of treatment and payment.

1. The insurance information I have provided is correct and I authorize Eli Abbo, DMD, PA to seek reimbursement from my insurance company.

2. I understand that after examination, the doctor will recommend treatment based upon what he/she feels is in the interest of my health, well-being, or appearance. The treatment may or may not be covered by my insurance. Possible reasons that insurance will not cover treatment include:

   a. The procedure or service is not approved for reimbursement by the policy.
   b. The patient has exceeded the benefits allowable under the plan.
   c. The treatment is considered cosmetic in nature.
   d. The required referral or pre-authorization was not obtained.

3. I understand that even if treatment is covered by my insurance, my plan may have a deductible or require co-payments or coinsurance and I am personally responsible for the portion of the fee not paid by my insurance.

4. I understand that I am personally responsible for payment of fees for all services. Any reimbursement provided by my insurance company will be credited to my account.

5. I agree that I will make payment for all fees at the time of service unless prior arrangements have been agreed upon in writing.

I have read and understand the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian