Allen Dental Group

Insurance and Consent

MEDICAID/DENALI KID CARE ID# _____ *Please Provide proof of eligibility.*

PRIMARY INSURANCE: *Please bring a copy of your card to appointments.*

Policy Holder Name: _____ Relationship to patient: _____

ID #: _____ Date of Birth: _____ Employer: _____

Name of Insurance: _____ Group #: _____ Phone #: _____

Claim Mailing Address: _____

SECONDARY INSURANCE: *Please bring a copy of your card to appointments.*

Policy Holder Name: _____ Relationship to patient: _____

ID #: _____ Date of Birth: _____ Employer: _____

Name of Insurance: _____ Group #: _____ Phone #: _____

Claim Mailing Address: _____

CONSENT & ASSIGNMENT OF BENEFITS:

- I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need, once I have been informed.
- I assign payment of all insurance benefits otherwise payable to me, directly to Dr. Allen and/or Dr. Engibous.
- I understand that **I am responsible for payment of services when rendered** and also responsible for paying and co-payment and deductible that my insurance does not cover at each visit. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. I authorize Allen Dental Group to contact myself at any phone number, email address, or cell phone number I have provided on this registration or given verbally.
- I will inform the office of any change in my or my child's health and/or medications, family information, financial responsibly or insurance coverage. I will not hold Bradford Allen, D.D.S, Paul Engibous, D.D.S., Allen Dental Group, or any staff member responsible for any errors or omissions that I have made in completion of this form.
- If our Doctors determine that there may be a potentially medically compromised situation, medical consultation may be needed prior to starting dental treatment. I authorize Bradford Allen, D.D.S or Paul Engibous, D.D.S to contact my or my child's physician.
- I have received a copy of the Appointment/Financial Policy and agree to comply.

Signature of **Responsible Party**_____ **Date**_____

Print Name _____