Always Genial
Dental Care P.C.

FINANCIAL POLICY / INSURANCE INFORMATION

Date: _____

Patient Name: _____ **Birthdate:** _____

Do you have Dental Insurance Coverage? ( ) Yes or ( ) No
If yes, please complete this portion.

Policyholder Name: _____ Birthdate: _____

Relationship:_____ Member ID # _____

Employer Name: _____ Group#: _____

Dental Insurance Company: _____ Phone Number: _____
(example: Aetna, Cigna, Delta, Met Life, BC/BS etc.)

Do you also have Secondary Dental Insurance Coverage? ( ) Yes or ( ) No
If yes, please complete this portion.

Policyholder Name: _____ Birthdate: _____

Relationship:_____ Member ID # _____

Employer: _____ Group#: _____

Dental Insurance Company: _____Phone Number:_____
(example: Aetna, Cigna, Delta, Met Life, BC/BS etc.)

We will gladly submit insurance claims on the patient's behalf.
Payment/copay is expected at the time services are rendered.
We accept cash, checks and credit cards.
Extended financial arrangements are available (Care Credit)

***** I authorize the release of any information or records of treatment rendered to third party payers and/or other healthcare practitioners.***
***** I certify that I understand that my insurance carrier may pay less than the estimated co-payments and I am financially responsible for services rendered.***

_____ _____
Signature of Patient/Legal Guardian ***Date***