The Dental Office of Solon

Insurance Information

Insurance Company: _____ Phone: _____

Address:

_____

Group #: _____

Policy Holder's Name: _____

Policy Holder's Employer: _____

Policy Holder's SS# or ID#: _____

Policy Holder's Date of Birth: _____

Relationship to Patient: _____

Is the patient covered by additional insurance? YES / NO

Do you want your insurance company to pay The Dental Office of Solon directly? YES / NO

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to The Dental Office of Solon all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Office Use Only: _____

Identification checked by staff? Initials: _____