Gulf Coast Oral & Facial Surgery

Failure to complete Medical and/or Dental information will result in your account being considered private pay and you will be required to pay for services in full and seek benefits from your carrier.

DENTAL INSURANCE

PRIMARY DENTAL INSURANCE:

Employer:_____

_____

Ins. Co. Name:_____

ID #:_____

Group#:_____

Address:_____

Tel. (_____)_____

Insured Party:_____

Relation:_____Date of Birth:_____

Sex: ❑ Male ❑ Female

S.S.#:_____Tel.(_____)_____

Address:_____

_____

SECONDARY DENTAL INSURANCE:

Employer:_____

_____

Ins. Co. Name:_____

ID#:_____

Group#:_____

Address:_____

Tel. (_____)_____

Insured Party:_____

Relation:_____Date of Birth:_____

Sex: ❑ Male ❑ Female

S.S.#:_____Tel. (_____)_____

Address:_____

_____

MEDICAL INSURANCE

PRIMARY MEDICAL INSURANCE:

Employer:_____

Plan:_____

Bus. Tel. (_____)_____

Ins. Co. Name:_____

Address:_____

_____

Tel. (_____)_____

ID#:_____

Group #:_____Group Name:_____

Insured Party:_____

Relation:_____Date of Birth: _____

Sex: ❑ Male ❑ Female

S.S.#:_____Tel.(_____)_____

Address:_____

_____

SECONDARY MEDICAL INSURANCE:

Employer:_____

Plan:_____

Bus. Tel. (_____)_____

Ins. Co. Name:_____

Address:_____

_____

Tel. (_____)_____

ID#:_____

Group #:_____Group Name:_____

Insured Party:_____

Relation:_____Date of Birth_____

Sex: ❑ Male ❑ Female

S.S.#:_____Tel.(_____)_____

Address:_____

_____

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Gulf Coast Oral & Facial Surgery or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Gulf Coast Oral & Facial is unable to collect from my insurance carrier for whatever reason.

As a courtesy, we are happy to file your insurance forms. Your insurance policy is an agreement between you and your insurance company. However, if for any reason your insurance has not paid their portion within 60 days from the date of service, you will be responsible for the remaining balance. Please be aware that some procedures may not be covered under your plan.

PATIENT / GUARANTOR SIGNATURE:_____DATE:_____