THE CENTER FOR **NaturalDentistry**

Insurance Questionnaire

We will gladly assist you in filing a claim with your insurance provider for your treatment. If you have dental insurance, please complete the form below and we will print a claim for following each appointment for you. That form may then be mailed in to your insurance provider for direct reimbursement up to your allowable limits.

Each insurance plan has its own unique set of frequencies, coverages and limits. Due to current privacy laws, many insurance companies will not provide us with any information regarding your plan. It is your responsibility to obtain benefit or reimbursement information.

Patient Name: ____

Gender: Male / Female DOB: ____/_____/_______ SSN: ______-_____-______

Insurance Provider: ____

Claim Address: ____

Group #: ______________________________ ID #: _____________________________________

Employer Name: ____

Subscriber Name: ____

Subscriber Address: ____

Subscriber SSN: _________-_________-__________ Subscriber DOB: ______/______/______

Relationship to Subscriber: Self / Spouse / Child / Other: ________________________________

Please keep in mind that your insurance policy is an agreement between you and the insurance company that provides your benefits. Not all services may be covered by your insurance, and all fees are the patient's responsibility. Every insurance plan has its own unique limitations and exceptions. We cannot guarantee your individual coverage or reimbursement of any or all products or services rendered.

(sign and date) ____