INSURANCE INFORMATION AND AUTHORIZATION

Insured's Name _____ Insured's Soc. Sec. # _____
(Last) (First) (Middle)

Insurance Company _____ Group No. _____

Insurance Co. Address _____ Ph. # _____
(Street) (City) (State) (Zip)

Is policy connected with your union? Yes___ No___ Name of Union _____ Local No. _____

DO YOU HAVE ADDITIONAL INSURANCE? Yes___ No___ IF YES, COMPLETE THE FOLLOWING:

Insured's Name _____ Insured's Soc. Sec. # _____

Work Phone _____ Insured's Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Employer Address _____
(Street) (City) (State) (Zip)

Insurance Company _____ Group No. _____

Insurance Co. Address _____ Ph. # _____
(Street) (City) (State) (Zip)

Is policy connected with your union? Yes___ No___ Name of Union _____ Local No. _____

Release of Information / Financial Responsibility / Authorization for Payment / Signature on File

The following information is provided to assist you in understanding our Insurance Policy. As a dental care provider, our relationship is with you the patient, not with your insurance company. Insurance is a benefit and a contract between YOU and YOUR insurance carrier. We have no contract, association, or connection of any type with any insurance company (other than select Delta plans).

As a courtesy, we will be happy to file insurance claims on your behalf. If eligibility is a question, we will be happy to call your carrier or employer. However, if they give us information which is incorrect, it will be your responsibility to negotiate unpaid claims. At your request, we will pre-authorize any diagnosed treatment to avoid confusion between you and your insurance company. Please let us know prior to your treatment if you would like a pre-authorization submitted to your insurance company. We can only estimate your anticipated portion. Even if a Pre-Authorization of benefits is obtained, plans are limited to coordination of benefits, plan year maximums, deductibles, plan limitation, and eligibility. You are responsible for any portion not covered by your insurance plan. Our office will bill your insurance upon completion of your treatment. If payment has not been received from your insurance company within 30 days form the completion of treatment, you will be responsible and billed for the balance.

I authorize the office of Strober Dental to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my employment with _____. I hereby authorize payment of dental benefits otherwise payable to me, directly to the office of Strober Dental.

To the extent permitted under applicable law, I authorize release of any information relating to the claim. This "Authorization" will be valid from this date and shall expire in one year. A photocopy of this document may act as an original. In addition, my signature below indicates that I have read and understand my financial responsibility.

_____ _____
Signature of Insured Witnessed By

_____ _____ _____
Signature of Patient (Parent or Responsible Party) Today's Date Expiration Date

Strober Dental
3330 Third Avenue, Suite 302, San Diego, CA 92103-5639, Ph (619) 299-5925, Fax (619) 299-5843