Offices for Heather Bond Southard, DDS

Primary Insurance Information

Insurance Company: _____

Insured ID: _____Group Number: _____

Insured Party Information:

Name: _____
Last **First** **MI**

Relationship to Patient: _____ Email: _____

Mailing Address: _____
City **State** **Zip**

Home Phone: _____ Work Phone: _____ Cell: _____

SS# _____ Date of Birth: _____

Secondary Insurance Information

Insurance Company: _____

Insured ID: _____Group Number: _____

Insured Party Information:

Name: _____
Last **First** **MI**

Relationship to Patient: _____ Email: _____

Mailing Address: _____
City **State** **Zip**

Home Phone: _____ Work Phone: _____ Cell: _____

SS# _____ Date of Birth: _____

INSURANCE AGREEMENT

As a courtesy to our patients with insurance, we will take care of all necessary paperwork associated with filling your claim. We will do everything that we can to maximize your insurance. I understand that my insurance is a contract between my insurance company, and me, the total balance for any necessary treatment is my responsibility.

I understand that it is my responsibility to know the limits of my insurance coverage. We do our best to forewarn you if a procedure will likely not be covered by your insurance.

_____ _____

Signature of patient/parent or guardian Date