ADVANCED SEDATION & GENERAL DENTISTRY

Anthony N. Altieri, DMD

DENTAL INSURANCE INFORMATION

WHO IS RESPONSIBLE FOR THIS ACCOUNT (if other than self)

Name of responsible party ____

Relationship to patient ___________

Address ____

Home phone _____________ Work phone ____________ Cell phone __________

Employer _______________________ Occupation ________________________

DENTAL INSURANCE INFORMATION

Insured's Name _____________________ SS#______________Birthdate________

Insured's Employer ___________________________work phone______________

Employer Address ____

Name of Insurance Company ______________________Phone________________

Insurance Company Address ____

By signing this document I assign insurance payment to Advanced Sedation & General Dentistry for services provided to myself or a family member.

I understand that Advanced Sedation & General Dentistry is not "in-network" or "contracted" with any dental insurance company and they will submit my dental claims as a courtesy to me.

I understand that I am responsible for all balances that are unpaid by the insurance company.

Signature of Responsible Party ______________________________________

Today's Date ___________________