Island Oral Surgery and Implant Group

Dental Insurance Form

Patients Name ______________________ **Date of Birth** ______________________

Employee's Name ______________________ **Relationship to Patient** ______________________

Date of Birth ______________________ **Place of Employment** ______________________

Employee's Social Security # ______________________ **Group #** ______________________

Name of Insurance Company ____

Phone # of Insurance Company ____

Address of Insurance Company ____

____

____

***<u>All</u> co-payments must be paid at the time services are rendered, please do not ask to be billed. If an extended payment plan is needed, please ask the front desk before your treatment begins for alternative payment options. Please understand that the full cost of your treatment is your responsibility. If your insurance company pays less than we have estimated, <u>any unpaid balance will be your responsibility.</u>**

______________________________________ ______________________________

Patient/Legal Guardian's Signature **Date**

Island Oral Surgery and Implant Group

Medical Insurance Form

Patients Name______________________________ **Date of Birth**____________________

Employee's Name____________________________ **Relationship to Patient**______________

Date of Birth______________________________ **Place of Employment**________________

Employee's Social Security #____________________ **Group #**________________________

Name of Insurance Company ____

Phone # of Insurance Company____

Address of Insurance Company ____

____

____

*** <u>All</u> co-payments must be paid at the time services are rendered, please do not ask to be billed. If an extended payment plan is needed, please ask the front desk before your treatment begins for alternative payment options. Please understand that the full cost of your treatment is your responsibility. If your insurance company pays less than we have estimated, <u>any unpaid balance will be your responsibility.</u>**

______________________________ _______________________

Patient/ Legal Guardian Signature Date