**THIS MUST BE FILLED IN FOR US TO PROCESS YOUR INSURANCE**

**PATIENT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_D.O.B\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMPLOYEE NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_D.O.B\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**COMPANY NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CO. ST. ADDRESS CTY, ST, ZIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INSURANCE CO. NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INS ST. ADDRESS CTY, ST ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE# ( ) \_\_\_\_\_\_\_\_\_\_\_\_**

**GROUP OR POLICY#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GROUP OR UNION NAME\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WHERE DOES YOUR CLAIM GO? EMPLOYER, INS CO, ADMINISTRATOR CIRCLE ONE**

**PATIENT RELATION TO EMPLOYEE? SAME, SPOUSE, CHILD, OTHER \_\_\_\_\_\_\_\_CIRCLE ONE**

**INSURANCE I.D.# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IF YOU HAVE SECONDARY INSURANCE PLEASE COMPLETE THIS SECTION**

**EMPLOYEE NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_D.O.B\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**COMPANY NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CO. ST. ADDRESS CTY, ST, ZIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INSURANCE CO. NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INS ST. ADDRESS CTY, ST ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE# ( ) \_\_\_\_\_\_\_\_\_\_\_\_**

**GROUP OR POLICY#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GROUP OR UNION NAME\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WHERE DOES YOUR CLAIM GO? EMPLOYER, INS CO, ADMINISTRATOR CIRCLE ONE**

**PATIENT RELATION TO EMPLOYEE? SAME, SPOUSE, CHILD, OTHER \_\_\_\_\_\_\_\_CIRCLE ONE**

**INSURANCE I.D.#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ASSIGNMENT OF BENEFITS**

**THE UNDERSIGNED PATIENT, IN REQUESTING EXAMINATION AND /OR TREATMENT, AUTHORIZES THE RELEASE OF ALL INFORMATION (INCLUDING X-RAYS) RELATING TO THAT EXAMINATION OR TREATMENT TO HEALTH SERVICE PLANS AND INSURANCE COMPANIES.**

**THE UNDERSIGNED PATIENT ALSO AUTHORIZES THE RELEASE OF SUCH INFORMATION TO ANY PEER REVIEW COMMITTEE OR STATE AND LOCAL DENTAL ASSOCIATIONSWHICH MAY REQUEST IT OR ANY OTHER PARTY THE PATIENT REQUEST.**

**I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DENTIST, DR. BRIAN BROWN, OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME, BUT NOT TO EXCEED THE ACTUAL CHARGFES NOT COVERED BY THE GROUP INSURANCE BENEFITS. YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE CARRIER. THE DOCTOR CAN IN NO WAY ALTER YOUR CONTRACT NOR GUARANTEE PAYMENT FROM YOU INSURANCE CARRIER. AS A CONVENIENCETO OUR PATIENTS WE WILL NORMALY BE HAPPY TO COMPLETE THE NECESSARY FORMS. HOWEVER, OUR OFFICE RESERVES THE RIGHT TO REJECT ANY FORMS OR TYPES OR CARRIER OF INSURANCE.**

**OUR OFFICE WILL BE EXPECTED TO BILL YOUR INSURANCE ONLY ONCE, IF AFTER 30 DAYS PAYMENT IS NOT PAID YOU ARE RESPONSIBLE FOR THE PAYMENTS IN FULL AND ALL COLLECTION COST.**

**BROWN FAMILY DENTISTRY**

**7126 N SHADELAND AVE #B**

**DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INDIANAPOLIS, IN 46250**

**PATIENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 317 842 6402**

**RESPONSIBLE PARTY SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**