Molar Magic
General Dentistry and Orthodontic
for Kids and Young Adults

Commercial Insurance Information

Patient Name_____ **Patient Date of Birth**_____

Primary

Name of Insured: _____ Social Security # _____
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
City State Phone #

Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other _____

Insurance Plan Name and Address: _____

Secondary (if applicable)

Name of Insured: _____ Social Security # _____
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
City State Phone #

Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other _____

Insurance Plan Name and Address: _____

Insurance Authorization

Please initial each item and sign below

_____ I understand that payment is due **before** the services are rendered

_____ I authorize release of information to all my insurance carriers

_____ **I understand that I am responsible for any part of my bill not covered by my insurance**

_____ I authorize payment directly to my doctor

_____ I authorize my doctor to act as my agent in helping me obtain payment from my insurance

_____ I understand that if I receive payment from my insurance company for procedures completed in this office I am responsible for the entire remaining balance at the office.

_____ _____ _____
Signature of patient, parent, or guardian Date Relationship to patient