

Mel Collazo, D.D.S., M.S.,
Specializing in Orthodontics and Facial Orthopedics
Dedicated to Providing the Finest Orthodontic Care

DENTAL Insurance Information
(Complete ONLY if you have Dental Insurance)

This information is needed in order to meet your orthodontic needs. It is considered strictly confidential.

“PRIMARY” Dental Insurance:

Subscriber Name _____ Subscriber Birth Date _____
Insurance Company _____ Insurance Tel# _____
Subscriber Social Security# or ID# _____ Group# (Plan, Local, or Policy#) _____
Relationship to Patient _____ Subscriber’s Employer _____
Do you have dual dental coverage? Yes _____ No _____ if yes complete the “Secondary” Dental Insurance section

“SECONDARY” Dental Insurance:

Subscriber Name _____ Subscriber Birth Date _____
Insurance Company _____ Insurance Tel# _____
Subscriber Social Security# or ID# _____ Group# (Plan, Local, or Policy#) _____
Relationship to Patient _____ Subscriber’s Employer _____

Responsible or Guarantor:

Patient’s Name _____ Patient’s Birth Date _____
Responsible Party Name _____ Relationship to Patient _____ Birth Date _____
Address _____ City/State/Zip _____
Cell Phone _____ Work Phone _____ Email _____
Responsible Party Social Security# _____ Employer _____

I understand that as the guarantor (patient) I am financially responsible for any balance not covered under the terms and conditions of my dental insurance coverage.

Signature of Guarantor _____ Date _____

KNOWLEDGEMENTS AND AUTHORIZATION

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I understand that charges not covered by my insurance company, as well as co-payments and deductibles are my responsibility and it is my obligation to inform the office of any changes in insurance coverage. I understand that services will be billed at our full fees. Services rendered for additional x-rays, appliances, cosmetic shaping or any dental related services will be billed when services are rendered. I understand that insurance may take up to 24 months to pay and that canceling or terminating my insurance does not release me from any payment obligations.

I authorize my insurance benefits paid directly to Mel Collazo, D.D.S., M.S., P. A.

I authorize Mel Collazo, D.D.S., M.S., P. A. to release any dental or other information to my insurance company when requested.

Signature _____ Date _____

Office Use only:

Verified by _____ Date of Verification _____