Mel Collazo, D.D.S., M.S.,P.A.

Specializing in Orthodontics and Facial Orthopedics

Dedicated to Providing the Finest Orthodontic Care

DENTAL Insurance Information

(Complete if you have Dental Insurance)

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

DENTAL INSURANCE - Primary

Patient Name_____________________________________ Patient Birthdate_______/________/__________

Insured Name_____________________________________ Insured Birthdate______/_________/__________

Insured Social Security #or ID#______________________ Relationship to Patient______________________

Insurance Company________________________________Insurance Tel#____________________________

Insured Employer_________________________________ Group# (Plan, Local, or Policy#)________________

Do you have dual dental coverage? Yes__ No___ if yes complete the "Secondary" Dental Insurance section

DENTAL INSURANCE – Secondary

Insured Name______________________________________Insured Birthdate_____/_________/___________

Insured Social Security #or ID#______________________ Relationship to Patient______________________

Insurance Company________________________________Insurance Tel#____________________________

Insured Employer_________________________________ Group# (Plan, Local, or Policy#)_________________

RESPONSIBLE or GUARANTOR (If different from Insured**)**

Patient's Name _______________________________________ Patient's Birthdate ______/_______/________

Responsible Party Name________________________ Relationship to Patient__________ Birthdate__ /__/___

Address____City/State/Zip_________________________________

Cell Phone_______________ Work/Other Phone_____________ Email______________________________

Responsible Party Social Security#______________________________Employer________________________

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.

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.

Parent / Guardian Signature____________________________ Date__________________

Office Use only: DDI: _________ M:_____________ Records Filed:________________

Verified by_______________ Date of Verification____________