INSURANCE INFORMATION

PRIMARY COVERAGE

Mail Claims To: _____
(Name of insurance company)

_____
(Complete mailing address)

Patient Information: _____
Last Name First Name M.I. Birthdate

Name of Insured: _____
Last Name First Name M.I. Birthdate

ID#: _____ Group#: _____

SECONDARY COVERAGE

Mail Claims To: _____
(Name of insurance company)

_____
(Complete mailing address)

Patient Information: _____
Last Name First Name M.I. Birthdate

Name of Insured: _____
Last Name First Name M.I. Birthdate

ID#: _____ Group#: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize Michael R. Errico, DDS, FICOI, FAGD, PC & Associates to furnish information to insurance carriers listed above concerning my treatments. I hereby assign to the physician all payments for dental services rendered to me or my dependents. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. This includes but is not limited to missed appointment fees, late co-pay fees and re-billing fees. I also agree that any expense incurred by Michael R. Errico, DDS, FICOI, FAGD, PC & Associates to collect the unpaid balance of the bill, including collection agencies, attorney fees, court costs and other expenses, will be added to the bill if such additional services are required. In the event that my account is turned over for collections, information that is necessary for collection purposes will be forwarded to our professional collection company.

Signed _____ Date _____
(Insured person/Parent/Guardian)

AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE COMPANY

I hereby authorize Michael R. Errico, DDS, FICOI, FAGD, PC & Associates to release to the insurance company(ies) listed above, any/all information acquired in the course of my or my dependent's examination and treatment.

Signed _____ Date _____
(Patient/Parent/Guardian)