

TAYLOR DENTAL

ASSOCIATES, INC.

Patient Insurance Information

As a courtesy to you we are happy to file your insurance claim for you. To receive this benefit you must help us by fully completing the information below. Thank you.

Patient's Name_____

Date of Birth_____

Primary Carrier ☐Dental ☐Medical

Secondary Carrier ☐Dental ☐Medical

Employee Information

Employee Information

Name_____SS#_____

Name_____SS#_____

Relationship to Patient_____

Relationship to Patient_____

Date of Birth_____

Date of Birth_____

Daytime Phone Number_____

Daytime Phone Number_____

Address_____

Address_____

Employee Insurance ID #_____

Employee Insurance ID#_____

Employer Name_____

Employer Name_____

Insurance Company Information

Insurance Company Information

Insurance Name_____

Insurance Name_____

Address_____

Address_____

Group Number_____

Group Number_____

Effective Date_____

Effective Date_____

Claims Phone Number_____

Claims Phone Number_____

Deductible Amount \$_____

Deductible Amount \$_____

Method of Payment ☐ UCR ☐ Schedule

Method of Payment ☐ UCR ☐ Schedule

Yearly Maximum Benefit \$_____

Yearly Maximum Benefit \$_____

Orthodontic Benefit ☐ Yes--Amount \$_____ ☐ No

Orthodontic Benefit ☐ Yes--Amount \$_____ ☐ No

If benefits are to be assigned please read and sign below.

I hereby authorize payment of the benefits otherwise payable to me to Taylor Dental Associates, Inc.

Insured Signature_____

Date_____

TAYLOR DENTAL ASSOCIATES, INC.
920 NORTH MAIN ST
TAYLOR, TX 76574
(512) 352-5577 or 365-5872

WILLIAM CABANISS, D.D.S. MARK FALKE, D.D.S.

Office Policy on
Standard Insurance and Network Insurers

In order to accommodate the needs and request of our patient, we file insurance as a courtesy. We can file with your insurance if you have the freedom to choose your own dentist.

While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual requirements of the plans. Each one has different stipulations regarding how often services may be rendered and more importantly any guidelines your policy may have. Even within the same insurance company, the plans differ upon what type of contract your employer has negotiated.

Providing quality dental care for our patients is our primary concern. We are more than willing to work with you and your insurance for you the patient to get the best of care. We know from experience that all services are not always a covered expense. Unfortunately we have no choice but to bill you for those charges.

With your cooperation and help, you should be able to receive all benefits eligible for you, and we will be able to concentrate on your dental needs.

In order to control our cost of billing, we request payments or deductibles be paid at the time services are rendered. Frequently. Insurance companies require additional information from the patient before processing a claim. If you receive such notification in the mail, please fill out the necessary forms and mail it to your insurance company as quickly as possible.

Any remaining balance after insurance payment is your responsibility. Any questions about your coverage are your responsibility direct any concerns to your insurance carrier.

Prior to restorative and major dental services we will present a treatment plan and finalize any financial arrangements prior to scheduling. We have several options available to all patients.

I have read and understand the office policy stated above and agree to accept responsibility as described.

Signed _____ Social Security# _____

Printed Name _____ Date _____

Patients Name _____ Date of Birth _____