

QUASHA FAMILY DENTISTRY

Insurance Financial Responsibility & Assignment of Benefits Consent Form

Patient Name: _____
Date of Birth: _____
Date: _____

Primary Dental Insurance

Insurance Company: _____
Member/Subscriber Name: _____
Member ID #: _____
Group #: _____
Subscriber Date of Birth: _____
Employer Name: _____
Relationship to Patient: Self / Spouse / Child / Other

Secondary Dental Insurance (If Applicable)

Insurance Company: _____
Member/Subscriber Name: _____
Member ID #: _____
Group #: _____
Subscriber Date of Birth: _____
Employer Name: _____
Relationship to Patient: Self / Spouse / Child / Other

Insurance Acknowledgment & Consent

I understand that insurance benefits quoted are estimates only and that I am ultimately responsible for all charges not paid by my insurance company. I authorize Quasha Family Dentistry to submit claims, release information necessary for claim processing, and receive payment directly from my insurance carrier.

I certify that the information provided above is accurate and complete to the best of my knowledge.

Patient/Responsible Party Signature: _____
Date: _____

Office Representative Signature: _____
Date: _____

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