Dental Remedies

135 Jenkins St. Ste. 105A

St. Augustine, FL 32086

Primary Dental Insurance:

Name of insured:_____

Insured`s Birth Date:_____ ID#_____ Group#_____

Insured`s address: _____

_____

Patient`s relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plane Name: _____

Insurance Address:_____

Insurance company Phone Number:_____

Insurance Authorization:

○ By checking this circle,

I authorize my insurance company to pay the dentist all insurance benefits rendered.

I authorize the use of this electronic signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.