Kidz & Teen Dental

Syed M. Haider, D.D.S. PA **4100 Fairway Ct, Suite # 520,**

972-939-KIDZ (5439) **Carrollton, TX 75010.**

Patient Name: _____ Patient Date of Birth: _____

As a courtesy to our patients, we will be happy to file a claim to your insurance for you. In order for us to give you the most efficient service possible, you will need to provide our office with your current dental insurance information prior to your dental visit. You will be expected to pay your deductible and estimated insurance percentage the day services are rendered. Please select one or all options below that apply to you.

_____ **SELF PAY**: Initial here to attest that there is no active dental insurance coverage for this patient. (This option waives the right to file a claim with any insurance carrier including Medicaid and CHIP)

_____ **DENTAL INSURANCE SINGLE COVERAGE**: Initial here if the patient has coverage with only one dental insurance company. Your insurance policy contract requires you to choose this option only if there is no additional coverage available.

_____ **DENTAL INSURANCE DOUBLE COVERAGE**: Initial here if the patient has coverage with more than one company including Medicaid and CHIP. Your insurance policy contract requires you to provide all policy information regardless of the benefits. You do not have the right to choose one policy over the other.

PRIMARY INSURANCE INFORMATION:

Insurance Name: _____ Policy Holder Name: _____

Policy Holder Date of Birth: _____ Name of Employer: _____

ID or Social Security #: _____ Group #: _____

SECONDARY INSURANCE INFORMATION:

Insurance Name: _____ Policy Holder Name: _____

Policy Holder Date of Birth: _____ Name of Employer: _____

ID or Social Security #: _____ Group #: _____

It is my responsibility to accurately inform the office of any insurance coverage prior to my visit. This is to include any changes in existing coverage's. I understand that I will be responsible for any charges resulting from my failure to provide the office with the correct information. I will be required to present proper insurance identification including any secondary coverage prior to my visit. By signing below, I confirm that the above information is true and accurate.

_____ _____ _____

PRINT NAME (Patient, Parent, Guardian) SIGNATURE DATE