



**All About Smiles Family Dentistry**  
 13 St. Johns Medical Park Drive  
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 YourSmileTeam@AllAboutSmilesDMD.Com

## INSURANCE INFORMATION FORM

(Please Print)

DENTAL INSURANCE			
(Please give your insurance card to the receptionist.)			
Who is responsible for this account?	Relationship to Patient:	Insurance Company:	Group #
Is this patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Subscribers Name:	Birthdate:	SS#:	Relationship to Patient:
<b>ASSIGNMENT AND RELEASE</b>			
<p>I certify that I, and/or my dependent(s), have insurance coverage with _____  <span style="margin-left: 400px;">Name of Insurance Company(ies)</span></p> <p>and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.</p> <p>The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.</p>			
_____ Signature of Patient, Parent, Guardian or Personal Representative			
_____ Please print name of Patient, Parent, Guardian or Personal Representative			
_____ Date		_____ Relationship to Patient	