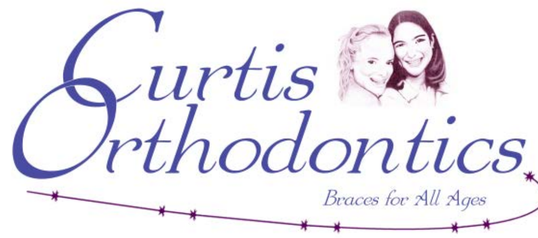

Billing/Insurance Information

Primary Billing Party	Secondary Billing Party (if needed)
Name____	Name____
Relationship to patient ____________________________	Relationship to patient ____________________________
Home#________________Cell#__________________	Home#________________Cell#__________________
Birthdate ______ / ______ / ___________	Birthdate ______ / ______ / ___________
SS# ________-________-__________	SS# ________-________-__________
Billing Address (If different from patient address)	**Billing Address** (If different from patient address)
Address______________________________________	Address______________________________________
____ City State Zip	____ City State Zip
Insurance Coverage	**Insurance Coverage**
Insurance Company ___________________________	Insurance Company ___________________________
Insurance ID# _______________________________	Insurance ID# _______________________________
Group# ___________________________	Group# ___________________________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Dr. Curtis all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____ ______ / ______ / ____________

Responsible party signature Date

Tod J. Curtis, DDS MS
2610 Smile Lane
Bedford, Indiana 47421
(812) 279-9473