DOUGLAS A. HENKE D.D.S., M.S.

Prosthodontics & Implantology

DENTAL INSURANCE INFORMATION SHEET

Please Read: Zahler and Henke, PC does not participate with any insurance companies. As a courtesy to our patients, Zahler and Henke, PC will submit your dental claim to your dental insurance company for reimbursement of your services. Our staff will inform you whether your particular insurance company will make payment to the office of Zahler and Henke PC or to you, the patient, directly. Your insurance company may not operate the same with our office as other offices. You must realize that your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. Since Zahler and Henke PC does not participate with any insurance companies we do not have insurance fee schedules which does not allow us to give you an exact estimate of what your insurance will pay towards any services. Any estimates given are exactly an estimate only and you will be responsible for the amount your insurance does not pay to our office. If your insurance pays you directly, you are responsible for making a payment to our office in that amount whether it's a personal check, credit card, or you may sign over the insurance check to our office. Below please fill out the information required to allow us to submit your claim(s) to your dental insurance. Please note, our office submits to dental insurance companies only. We do not bill to any medical insurance companies.

If you have any questions regarding this form, our friendly staff can assist you. By completing this form you are agreeing to have read the above information and understand your balance is your responsibility and any amount your insurance does not cover is your responsibility.

_____ _____ _____

Patient Name (Please Print) Date Patient Signature

PRIMARY DENTAL INSURANCE CARRIER: _____

POLICY HOLDERS FIRST AND LAST NAME: _____
(AS IT APPEARS ON INSURANCE CARD, YOU OR SPOUSE/PARENT)

INDICATE RELATIONSHIP TO POLICY HOLDER: _____
(PARENT OR SPOUSE)

YOUR DATE OF BIRTH: _____ POLICY HOLDERS DATE OF BIRTH:_____
(PARENT OR SPOUSE D.O.B.)

POLICY HOLDER SOCIAL SECURITY NUMBER OR CONTRACT NUMBER: _____

PLEASE NOTE: IF YOU'RE INSURANCE CARRIER IS METLIFE, DELTA DENTAL OR GUARDIAN, A SOCIAL SECURITY NUMBER IS REQUIRED TO SUBMIT YOUR CLAIM, IF YOU CHOOSE NOT TO PROVIDE US WITH THAT INFORMATION ZAHLER AND HENKE PC CANNOT SUBMIT YOUR DENTAL CLAIM, THEREFOR YOUR PAYMENT WILL BE REQUIRED IN FULL AT THE TIME OF SERVICE.
PRIMARY INSURANCE CLAIMS ADDRESS AS IT APPEARS ON INSURANCE CARD:

SECONDARY DENTAL INSURANCE CARRIER: _____

POLICY HOLDERS FIRST AND LAST NAME: _____
(AS IT APPEARS ON INSURANCE CARD, YOU OR SPOUSE/PARENT)

INDICATE RELATIONSHIP TO POLICY HOLDER: _____
(PARENT OR SPOUSE)

POLICY HOLDERS DATE OF BIRTH:_____
(PARENT OR SPOUSE D.O.B.)

POLICY HOLDER SOCIAL SECURITY NUMBER OR CONTRACT NUMBER :
_____

SECONDARY INSURANCE CLAIMS ADDRESS AS IT APPEARS ON INSURANCE CARD: