Dr. C.A. Tsiatis
207-12 Northern Boulevard
Bayside, NY 11361
Phone: (718) 631-2900

Clearview Dental

Dental Insurance Information and Authorization

Dental Insurance Company: _____

Group Number: _____

Name of Insured: _____ Member ID: _____

Member Date of Birth: ____/____/____ Member Social Security Number: ____-____-____
MM/DD/YYYY

Name of Employer or Union: _____

Insurance Mailing Address: _____

Insurance Telephone Number: _____

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by the law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by the law, I consent to your use or disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____
Patient/Guardian signature Date

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X_____
Subscriber signature Date

I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for the balance of my dental account regardless of my insurance.

X_____
Subscriber signature Date