WEST ANNAPOLIS FAMILY DENTISTRY
101 RIDGELY AVE. SUITE 20
ANNAPOLIS, MD. 21401

Dental Insurance Information

Date _____

In the event that I cannot supply insurance information on the day of my appointment, I agree to be responsible for any debt incurred on that date of service. I also agree to be responsible for any remaining balance after insurance payments are made.

Insurance claims will be submitted within one month of the visit and if I fail to provide adequate information for billing I will be responsible for any debt.

PLEASE LIST PRIMARY DENTAL INSURANCE:

(1)_____

SECONDARY DENTAL INSURANCE:

(2)_____

AND / OR ANY ADDITIONAL DENTAL INSURANCE YOU MAY HAVE.

_____

PRINT PATIENT'S NAME

_____

PATIENT'S SIGNATURE