



Today's Date:	Person responsible for Account	Relationship to patient:
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PATIENT INFORMATION

Patient's last name:	First:	Middle:	Birthday:
Address:			
Home phone no.:	Cell phone no.:	Work phone no.	
Other family members seen here:			

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group name:	Group no.:	Member I.D No.:
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Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name: & S.S No.	Group no.:	Member ID No.:
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Patient's relationship to subscriber: | Other:

IN CASE OF EMERGENCY

Name of person to contact in case of an emergency	Relationship to patient:	Home phone no.:	Work/Cell phone no.:
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Little smiles On Broadway or insurance company to release any information required to process my claims.

Patient/Guardian signature	Date
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ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependant) have insurance coverage with _____ and assign Little Smiles on Broadway 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 herby 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.

Parent/Guardian Signature _____ - _____ Date: _____

(initial each section below if applicable) **Authorization to use Signature On File**

I request that payment under the dental insurance program be made either to me or to the provider(s) named above on any bills or services furnished to me during the effective date of this authorization. _____

I authorize the use of the words "Signature on File" in place of my signature on claim forms to authorize release of any information relating to this claim for the purpose of making payment. _____

I have read and understand the following New York State mandated Insurance Claim Fraud Notice. _____

Any person who knowingly and with intent to defraud any insurance company or other persons files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to civil and criminal penalties.

Optional assignment of benefit authorization – I authorize payment to be made directly to the provider(s) named above and on the claim form which would be otherwise payable to me. _____

Signed: _____ Date: _____
 Print name: _____

