SMILE
Wellness Co.

**Dental Insurance Information**

Who is responsible for this account? _____Relationship to Patient: _____

Primary Dental Insurance: ☐ Yes ☐ No

Secondary Dental Insurance: ☐ Yes ☐ No

**Assignment and Release**

Insurance Company: _____

Group#: _____

Insurance Address: _____

City: _____ State: _____
Zip:_____

Subscriber's Name: _____

DOB: _____SS#: _____

Employer: _____

Insurance Company: _____

Group #: _____

Insurance Address: _____

City: _____ State: _____
Zip:_____

Subscriber's Name: _____

DOB: _____ SS#: _____

Employer: _____

I certify that I, and/or my dependent(s) have insurance coverage with _____ name of Insurance Company(ies) and assign directly to Dr. Jolyn Su 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 authorize the use of my signature on all insurance submissions.

Dr. Jolyn Su may use my health card information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

Signature of Patient or Guardian | Please print name of Patient or Guardian

_____ _____

Date | Relationship to Patient

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