ALAMO DENTALHEALTH
Change Your Smile, Change Your Life.
8647 Wurzbach Rd., Building B, San Antonio, TX 78240
Office: 210.691.1211 Email: NewSmiles@adhsa.com

Insurance Agreement

We appreciate your selection of our dental office to serve your complete health dentistry needs. While your insurance is an agreement between you, your employer, and your insurance carrier, we want to make accessing you benefits as easy as possible. As a courtesy to you, we will assist you in filing your claim, work directly with your insurance, and provide the necessary information to maximize the reimbursement on your claim. After 30 days, any overpayment from your insurance company will be applied to your credit card and any balance remaining will be charged to your credit card. Secondary dental insurance will be filed but is not utilized as a form of payment.

Primary DENTAL Insurance

Subscriber Name: _____ Date of Birth: _____

Address: _____ Employer: _____

Patient's relationship to insured: □ self □ spouse □ child □ other Subscriber's SS#:_____

Insurance Company: _____ Phone: _____

Subscriber ID #: _____ Group #: _____ Group Name: _____

Insurance Address: _____

Secondary DENTAL Insurance

Subscriber Name: _____ Date of Birth: _____

Address: _____ Employer: _____

Patient's relationship to insured: □ self □ spouse □ child □ other Subscriber's SS#:_____

Insurance Company: _____ Phone: _____

Subscriber ID #: _____ Group #: _____ Group Name: _____

Insurance Address: _____

Credit Card Information

Visa_____ MasterCard_____ Discover_____ Amex_____

Name on card:_____ Card Number:_____ Exp: _____

CCV:_____ Billing address:_____City:_____ State:_____ Zip:_____

Insurance Authorization:

- I authorize my insurance company to pay the doctor all insurance benefits rendered.
- I authorize the use of this signature on all insurance submissions.
- I authorize the doctor to release all information necessary to secure the payment of benefits.
- I understand that I am financially responsible for all charges unpaid by the insurance. If there is any unpaid balance after 30 days from the date the claim was sent I authorize my credit card on file to be charged for the full unpaid balance.
- If I receive a reimbursement check from my insurance, I will notify the doctor immediately and turn over the funds to be applied to my treatment.

_____ _____ _____
Patient's Name (please print) Signature of Patient (or Guardian, if applicable) Date

_____ _____ _____
Cardholder's Name (please print) Signature of Cardholder Date