

# DOBBIN DENTAL SUITE

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## INSURANCE INFORMATION

As a courtesy to our patients, we file your dental insurance. Dental insurance is not like medical coverage and rarely covers the same percentages. Your dental insurance is a contract between your employer and your insurance company for your benefit. The professional treatment and dental services offered by Dobbin Dental Suite are for your best oral health and will not be dictated by insurance coverage.

You are responsible for the deductible and percentage not covered by insurance for the work performed by Dobbin Dental Suite on the day of service. For insurances that do not pay our office directly, you will be responsible for payment in full and we will submit insurance claims with payments to be sent to you. We have many payment options, including cash, credit, or check, and we are available at any time to discuss the best option for you.

We file many of our claims electronically, therefore a signature on file is required by all dental insurance companies. We must have a completed insurance form along with social security number and date of birth to file your insurance.

We will always do our best to help you maximize your dental benefits, however, ultimate responsibility for payment is yours and financial arrangements must be defined prior to beginning treatment.

## INSURANCE INFORMATION NEEDED TO FILE YOUR CLAIM

Policy Holder's Name: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Group Number: \_\_\_\_\_ Subscriber ID: \_\_\_\_\_  
Policy Holder's SS#: \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_\_

Policy Holder's Employer Name: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

**\*\*If you have a secondary insurance, please check here  and fill out another insurance information form.**

## RELEASE OF INFORMATION

I authorize release of any dental information necessary to process insurance claims.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## FINANCIAL POLICY

If it becomes necessary to send my account for collection, I understand and agree that I will pay reasonable and customary attorney's fees, all cost of suit and fees owed to the Corporation of Dobbin Dental Suite.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I understand that should I elect not to sign this agreement, I agree to pay at the time of service regardless of insurance coverage.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_