BROOKLINE DENTAL STUDIO
1247-A Beacon Street • Brookline, MA 02446 • Tel. (617) 566-5400 • FAX (617) 731-1535

SUBSCRIBER INFORMATION / ОТВЕТСТВЕННЫЙ ЗА СТРАХОВКУ

Date / Дата _____

First Name / Имя _____ Last Name / Фамилия _____

Date of Birth / День Рождения (месяц/день/год) _____ / _____ / _____

Address / Адрес _____

City / Город _____ State / Штат _____ Zip Code / Индекс _____

Home Ph.# / Дом. Телефон _____ Fax # / Но. Факса _____

Work Ph. # / Раб. Телефон _____ E-mail _____

Occupation / Профессия _____

Sex / Пол: ☐ Male ☐ Female Social Security Number _____

Marital Status / Семейное положение: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

INSURANCE INFORMATION *(If you wish us to process Insurance Claims, This portion **MUST** be completed)*

How many dental insurances do you have? / Колличество страховок: ☐ One ☐ Two ☐ Three ☐ Four

Who is Responsible for this Insurance / Кто ответственный за Страховку? _____

Relationship to Subscriber / Ваше отношение к ответственному за страховку:

☐ Self ☐ Spouse ☐ Child ☐ Other _____

Person Responsible employed by / Название компании _____

Business address / Адрес работы _____ City / Город _____

State / Штат ____ Zip Code / Индекс _____ Work Ph. # / Раб. Телефон _____

Insurance Company / Страховая Компания _____

Group # _____ Subscriber # _____

Annual Maximum $ _____ From / С _____ / _____ / _____

I Preventative _____ % Till / До _____ / _____ / _____

II Basic _____ % Waiting Period ☐ Yes / Да ☐ No / Нет

III Major _____ % _____

Deductible $ _____ Ortho / Орто _____

Names of other dependents covered / Кто ещё включён в страховку? _____

_____

I have read and answered the above questions to best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I 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.

The patient will be given an estimated insurance co-payment figure. It is then the responsibility of the patient to pay this amount in full by the time their treatment is completed. If there is any difference in the estimated co-payment and the actual amount due after the insurance company has issued their payments, the patient will either be billed or issued a refund for the difference.

If the insurance company fails to pay their portion within 90 days of the treatment date, the patient is then responsible for the entire balance for the dental work. If and when the payment is received after the 90 days, and if the patient has already paid the entire balance, a refund in the amount of the insurance payment will be sent to the patient. In the event that a balance remains unpaid in 6 month after dental work was completed, a finance charge of 18 % of your total unpaid balance will be incurred.

I have read and understand the above statements and agreed to be subject to their terms and conditions.

Patient's Signature / Подпись _____ Date / Дата _____