Evergreen Dentistry
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Insurance Agreement

I certify that the insurance information is correct and in force. I am aware that it is **my responsibility to read and understand my own dental insurance policy**, including benefits, limitations and exclusion. I understand that an estimated portion is *due at the time of service,* and is estimated according to expected coverage which may not be disclosed nor guaranteed by my insurance company**. I understand that my portion may be more if my insurance company does not pay the anticipated amount**.

I understand that my insurance is a contract between me and my insurance company and not between Evergreen Dentistry and my insurance company. Evergreen Dentistry will bill my insurance for me as a courtesy only and I am responsible for any amount that my insurance company does not pay.

Recommended treatment is based on the professional judgement of Evergreen Dentistry, and not on the parameters of my insurance plan.

____ Date: _____________

Patient Signature/legally authorized representative

____ Date: _____________

Printed Name if signed on behalf of the patient

Primary Insurance

Subscriber Name: ______________________ Subscriber Birthdate: _______________

Are you a dependent? ◯ Yes ◯ No

Insurance Company: ____

Group #: ____

Social Security #, or Insurance ID #: ______________________ Group#: _______________

Secondary Insurance (if applicable)

Subscriber Name: ______________________ Subscriber Birthdate: _______________

Are you a dependent? ◯ Yes ◯ No

Insurance Company: ____

Group #: ____

Social Security #, or Insurance ID #: ______________________ Group#: _______________