

Simon Kappel DDS PC
1315-53 Street
Brooklyn, New York 11219
BROOKLYNDENTIST4U.COM 718-436-0202

Dental Insurance/Financial Responsibility Form

Patient's Name: _____

Patient's Date of Birth: _____

Father's Name: _____ Mother's Name: _____

Address: _____

City, State and Zip: _____

Home Phone #: _____

Father's Cell #: _____ Mother's Cell #: _____

Employer: _____

Employer: _____

Business Phone: _____ Business Phone:

Dental Insurance: _____ Dental

Insurance: _____

ID# _____ Group _____ ID# _____ Group

DOB: _____

DOB _____

This office is happy to cooperate with individuals who are covered by dental insurance. We only ask that you carefully read Your policy to be sure that you are fully aware of any restriction that apply to the benefits provided. Dental insurance is a Contract between the patient and the insurance company for reimbursing the cost of dental services. It is not a contract between the dentist and the insurance company. I understand that I am financially responsible for all services rendered by the Dentist.

I understand any co-payments, and/or procedure cost not covered or denied by my insurance company, (including coverageTermination prior to the date services are rendered) are MY responsibility.

This Dental office is authorized to fill out/or assist me to complete any and all insurance forms pertaining to services rendered.

Parent or guardian signature

Date

