Enhance Dental
1215 S. Fort Apache Rd Ste 230, Las Vegas, NV, 89117 (702) 437-1007
Enhancedental1@aol.com

Primary Insurance

Individual responsible for this account _____
(Last Name) (First Name) (I)

Relationship to Patient _____ Birth Date _____ SS# _____

Responsible Party Employed By _____ Business Phone _____
Insurance Company _____

Insurance Phone _____

Subscriber I.D. # _____ Group# _____

Additional Insurance

Insured Individual's Name _____
(Last Name) (First Name) (I)

Relationship to Patient _____ Birth Date _____ SS# _____

Insured Party Employed By _____ Business Phone _____

Insurance Company _____

Insurance Phone _____

Subscriber I.D. # _____ Group# _____

ASSIGNMENT AND RELEASE

I authorize my insurance company to pay Dr. Beatrice Stark all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARANGEMENTS HAVE BEEN APPROVED.