William A. Burn, III, DMD, PC

7897 Broad River Road

P.O. Box 2117

Irmo, SC 29063

Dental Insurance and Financial Items

Primary Dental Insurance

Name of Insured Person____

Relationship to Patient____

Birth Date__________________________________ Social Security #_____________________________

Employer____

Insurance Company____ Group #________________________

Insurance Company Address____

Insurance Company Phone #_______________________________________

Effective Date of Coverage____

Annual Deductible______________________ Maximum Annual Benefit_________________

Financial Information

I authorize Dr. Burn's office to release any medical, dental, and /or treatment information during the period of such dental treatment to third party payers and/or other health care professionals. I authorize and request that my insurance company pay any benefits directly to the dentist. Should I receive such payment in error, I will immediately deliver it to the dentist. I understand that filing dental insurance is a courtesy to me, and that the amount I am paying is only an estimate. I agree that if a balance remains after my insurance pays, I am fully responsible for that balance.

Patient Signature____ Date____________________