Warden Eglinton Dental Centre
1921 Eglinton Avenue East, Unit 8E
Scarborough, ON M1L 2L6
416-751-4290

PATIENT INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE CARRIER:

Insured's Name _____ SS# _____ Date of Birth_____

Insured's Employer_____ Employer's Address & Phone #_____

Insurance Carrier_____Group#_____Phone#_____

Insurance Carrier's Address_____

SECONDARY DENTAL INSURANCE CARRIER:

Insured's Name_____ SS# _____Date of Birth_____

Insured's Employer_____ Employer's Address & Phone #_____

Insurance Carrier_____

Group#_____ Certificate#_____ Phone#_____

Insurance Carrier's Address_____

AUTHORIZATION TO RELEASE MEDICAL/DENTAL INFORMATION:

I authorize the release of any medical/dental information necessary to process my insurance claim(s). I also certify that all insurance information given to **Warden Eglinton Dental Centre** is correct and complete. A photocopy of my signature shall be valid as original.

Patient's Signature_____

Insured's Signature_____

AUTHORIZATION TO PAY Warden Eglinton Dental Centre

I hereby authorize my insurance company to pay by check made out to and mailed directly to: **WE Dental**, hereafter known as **Warden Eglinton Dental Centre** the expense benefits allowable and otherwise payable to me under my current insurance policy, as payment towards the total charges for professional services rendered. This payment shall not exceed the total charges for the services performed by Dr. Pramiti Kohli. I agree to be responsible for my bill and any portion that the insurance company does not pay. I will pay any balance remaining within 30 days. I understand that WE Dental is not part of any dental plans. I understand that the staff of We Dental **cannot guarantee how much, or even if, my insurance company will pay** on a claim, since the insurance company has a contract with me and not with WE Dental and insurance plans vary widely in their allowable fees and covered charges. I further agree to immediately sign over to WE Dental without cashing, any insurance payments sent to me. If I should cash and hold these funds, I agree to pay WE Dental a **20% late fee** for the amount of any funds I may take. A photocopy of my signature shall be valid as original. If my insurance does not pay within 45 days of claim submission, I will be responsible for the payment and will follow-up with my insurance.

Print

Patient's Signature: _____

Insured's Signature: _____

WE FILE PRIMARY INSURANCE AS A COURTESY. THE PATIENT MUST FILE AND FOLLOW-UP WITH THE SECONDARY INSURANCE. WE WILL PROVIDE YOU WITH ALL THE NECESSARY PAPERWORK ON OUR PART TO FILE FOR YOUR BENEFITS.