ESPINAL & WILLIS
Carolinas Center for Advanced Dentistry
1144-F India Hook Rd.
Rock Hill, SC 29732

Ph. 803-327-4166
Fx: 803-327-2086
www.ccadonline.com

Insurance

Primary Insurance

Person Responsible for Account ____
Last Name First Name Initial

Relation to Patient ____

Address (if different from patient's) ______________________ Phone ______________

City ______________________ State ______________ Zip ______________

Person Responsible Employed by ______________________ Occupation ______________

Business Address ______________________ Business Phone ______________

Insurance Company ____

Contract # ______________ Group# ______________ Subscriber # ______________

Names of other dependents covered under this plan ______________________________

Authorization

I authorize my insurance company to pay to the dentist group 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.
I give authorization for this office to obtain information on me regarding my credit standing for the purpose of obtaining credit in this office.

Signature ____ Date ______________

Payment is due in full at time of treatment unless prior arrangements have been approved.