DENTAL INSURANCE:

Name of Insured/Policy Holder: _____

Insured's Relationship to Patient: ◯Self ◯Spouse ◯Parent ◯Step-Parent Other _____

Insured/Policy Holder Birth Date: _____ Insured/Policy Holder Soc. Sec.#_____

Name of lnsurance Company: _____ Phone# _____

Address For Claim Submission: _____

Employer: _____ Group# _____

Employer Phone Number: _____

Is treatment due to an accident or injury? ◯No ◯Yes **If yes, please alert the receptionist immediately.**

MEDICAL INSURANCE:

Name of Insured/Policy Holder: _____

lnsured's Relationship to Patient: ◯Self ◯Spouse ◯Parent ◯Step-Parent Other _____

Insured/Policy Holder Birth Date: _____ Insured/Policy Holder Soc. Sec.#_____

Name of lnsurance Company: _____ Phone #_____

Address to which we send claims: _____

Employer:_____ Phone # _____

FOR MEDICARE PATIENTS ONLY:

I understand that Dr. Frankie Gomez is not a participating provider for Medicare and is not responsible for filing of claims on my behalf. Any reimbursement for covered procedures that may be performed by Dr. Gomez will be sent directly to me upon my filing of the claim as per Medicare regulations.

Patient's Signature _____

ALL PATIENTS:

I acknowledge that the above information is correct and I agree to notify Dr. Gomez of any changes that may occur. I agree to pay any charges incurred and if I have insurance, I agree to pay any deductible, copayment or other amounts that may not be covered by my insurance plan. My signature below serves as authorization to Dr. Gomez to release any medical/dental records as required by law and HIPPA regulations for appropriate care with other providers; to process any insurance claims; and to receive payment/insurance benefits otherwise payable to the insured. I understand that there could be late charges and/or collections fees assigned to me as a result of non-payment of fees.

Signature of Responsible Party _____ Date _____

FRANKIE GOMEZ, DMD, MD

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