Neal W Rogol DMD, Inc.
24 Salt Pond Road, Unit G2
South Kingstown, RI 02879
401-214-0880

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION

Name of Insured:______________________________ Is insured a patient? ☐ Yes ☐ No

Insured's Birth Date:______________ ID #:__________ Group #:________

Insured'sAddress:____
Street City State Zip Code

Insured's Employer Name:______________________________

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name and Telephone:______________________________

Assignment of Benefits

I authorize payment of dental benefits to Neal W Rogol DMD, Inc. for professional services rendered and I authorize the release of any dental information necessary to process claims.

Name:______________________________ Date: __________

SECONDARY INSURANCE INFORMATION

Name of Insured:______________________________ Is insured a patient? ☐ Yes ☐ No

Insured's Birth Date:______________ ID #:__________ Group #:________

Insured'sAddress:____
Street City State Zip Code

Insured's Employer Name:______________________________

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name and Telephone:______________________________

Consent for Services

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. As a courtesy, Neal W Rogol DMD, Inc. will process and submit insurance claims after each visit. This dental office cannot render services on the assumption that your charges will be paid by an insurance company. The plan deductible and patient co-payments will be due at the time services are rendered.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding sixty (60) days, unless previously written financial arrangements are satisfied.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

______________________________ Date: __________
Signature of patient, parent or guardian