

Office of Dr. Gene C. Mears
RELEASE OF INFORMATION

I hereby authorize the following:

1. Any information regarding my treatment to myself and anyone listed below (spouse, parents, etc.)
2. Assignment of insurance payment to Dr. Gene C. Mears
3. The release of any and all medical information to other treating dentists and insurance carrier for the purpose of claims administration.
4. The release of any testing results from another treating dentist or facility in which testing was performed to Dr. Gene Mears
5. If applicable, I also authorize release of information to my attorney (with a signed order)

_____ Date

_____ Responsible Party Signature

Insurance Information

Please select one of the following:

I do not have dental insurance I do have dental insurance (*please complete the following*)

Primary Insurance Information – must be completed in full

Policy Holder: _____ Group #: _____

Policy Holder ID#: _____

Relationship to Policy Holder: Self Spouse Child Other

Policy Holder Soc. Sec.#: _____ Policy Holder Date of Birth: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____

Insurance Co: _____ Address: _____

City: _____ State: _____ Zip: _____

Secondary Insurance Information

Policy Holder: _____ Group #: _____

Policy Holder ID#: _____

Relationship to Policy Holder: Self Spouse Child Other

Policy Holder Soc. Sec.#: _____ Policy Holder Date of Birth: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____

Insurance Co: _____ Address: _____

City: _____ State: _____ Zip: _____

I acknowledge payment is due at time of treatment and I accept full responsibility for all charges. Furthermore, I acknowledge to inform this office as to my complete insurance coverage, noting any changes that have occurred at the time services are rendered. Failure to completely disclose all aspects of my insurance will deem me financially responsible for all charges from date of service. I understand that after 60 days, all pending insurance claims will become my responsibility.

_____ Date

_____ Patient/Guardian Signature

_____ Please Print Name