EXCELLENCE IN CARE,
SKILL AND JUDGEMENT

Deepa Suryanarayanan DMD
GENERAL DENTISTRY

INSURANCE INFORMATION (Primary) (Please Provide Insurance Card For Us To Copy.)

Insurance Co.: _____
Insurance Co. Phone: ( ) _____

Policy Holder:_____
Date of Birth: _____

ID/Policy #: _____ Group #: _____
Group Name: _____

INSURANCE INFORMATION (Secondary)

Insurance Co.: _____
Insurance Co. Phone: ( ) _____

Policy Holder: _____
Date of Birth: _____

ID/Policy #: _____ Group #: _____
Group Name: _____

_____

To the best of my knowledge, all of the above information is true and complete. I understand that I am responsible to pay for all services rendered to me, and that I am willing to make specific arrangements to pay whatever part is not covered by insurance on a timely basis. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. (**PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR, AND IS NOT A SUBSTITUTE FOR PAYMENT**.) **IN ORDER TO MONITOR YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.** Thank you.

PATIENT SIGNATURE:

_____

DATE: _____

4701 RANDOLPH ROAD #114-ROCKVILLE, MARYLAND 20852 301-770-5353
6525 BELCREST ROAD #212 -HYATTSVILLE, MD 20782 301-927-2900