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INSURANCE INFORMATION

Patient's Name: _____

Facility Name: _____

Name Of Dental Insurance: _____

Group Name: _____ Group Number: _____

Send Claims To (Address): _____

Name of Insured: _____

Relationship to Patient: _____

Social Security Number of Insured: _____ - _____ - _____ Date of Birth of Insured: ____/____/____

Dental Insurance Phone Number (For Eligibility and Claim Information): _____

All Information regarding dental insurance is necessary. If information is not complete, treatment may be delayed.

In accordance with the Privacy Regulations created by the Health Insurance Portability and Accountability Act of 1996 (HIPPA), we are required to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information that describes how we may use and disclose your protected health information to carry out treatment, payment of health care operation and for other purposes that we are permitted or required by law.

We will use and disclose your protected health information to provide, coordinate, or manage your dental care and any related services. For example: your health/dental information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information periodically to another dentist, physician or health care provider who becomes involved in your care.

We may use and disclose dental information about you in order to obtain payment for services rendered. Such disclosures may be made to you, an insurance company, responsible party or third party. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover treatment.

All fees are ultimately the responsibility of the responsible party.

Medical, Share-of-Cost Medi-Cal, Patient Trust accounts or Private Dental Insurance may be billed for Dental Hygiene Treatment. Fees for service rendered will be due and payable upon the completion of treatment. Third-party (insurance) payment will be disbursed directly to the patient or responsible party.

Medi-Cal

Please attach copy of current Medi-Cal Benefits Identification Card. Permission is authorized for direct payment to Dental Hygiene 2 U for Medi-Cal and Share-of-Cost Medi-Cal disbursements.

Medi-Cal Card Issue Date: _____

Medi-Cal coverage for dental hygiene treatment is usually once per full 12 month period. Special conditions and/or medications may determine more frequent treatment. Permission is granted to use Medi-Cal Share-of-Cost funds. Date of last dental prophylaxis/cleaning: _____

Signature of Responsible Party: _____ Date: ____/____/____

Signature of Power of Attorney
 For Health Care: _____ Date: ____/____/____