GERARD M. CUOMO, DDS, PA **(561) 391-6290**

INSURANCE INFORMATION

Patient Name: _____

Patient's Social Security Number: _____

Dental Insurance: _____

Policy Number: _____ Group Number: _____

If the dental insurance is in the name of someone other than the patient, please provide the following information:

Name of Insured: _____ Is Insured a patient? _____

Patient's relationship to Insured: _____ Insured Birth Date: _____

Insured Employer: _____ Insured SSN: _____

If you have Secondary Dental Insurance, please see the receptionist.

PLEASE HAVE YOUR INSURANCE CARD AVAILABLE FOR COPYING.

PATIENT AUTHORIZATION & FEE CONSENT

Lifetime Assignment of Benefits: I certify that I have insurance coverage as stated above and assign directly to Gerard M. Cuomo, DDS, PA, all insurance benefits, if any, otherwise payable to me for services rendered.

Lifetime Release of Information: I hereby authorize the doctor to release all medical information necessary to secure the payment of benefits.

Lifetime Signature on File: I authorize use of this signature on all insurance submissions.

Fee Consent: I understand that I am financially responsible for all charges whether or not paid by insurance.

Patient's Signature: _____ Date: _____