



**ESPINAL & WILLIS**  
 Carolinas Center for Advanced Dentistry  
 1144-F India Hook Rd.  
 Rock Hill, SC 29732

Ph. 803-327-4166  
 Fx: 803-327-2086  
 www.ccadonline.com

# Insurance

## Primary Insurance

Person Responsible for Account \_\_\_\_\_  
Last Name First Name Initial

Relation to Patient \_\_\_\_\_

Address (if different from patient's) \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_

Contract # \_\_\_\_\_ Group# \_\_\_\_\_ Subscriber # \_\_\_\_\_

Names of other dependents covered under this plan \_\_\_\_\_

## Authorization

I authorize my insurance company to pay to the dentist group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

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

I give authorization for this office to obtain information on me regarding my credit standing for the purpose of obtaining credit in this office.

Signature \_\_\_\_\_ Date \_\_\_\_\_

*Payment is due in full at time of treatment unless prior arrangements have been approved.*