Michael B. Lee, D.D.S.
Diplomate American Board of Oral & Maxillofacial Surgery

7523 State Road Cincinnati, Ohio 45255
513-232-8989 www.cincinnatijawsurgery.com

INSURANCE INFORMATION FORM

Patient Name: _____ DOB: _____

Parent/Guarantor: _____Relationship to Patient: _____

Please indicate responsible party for billing: _____
Place of Employment: _____ DOB: _____
Social Security # _____ Marital Status: _____

If you do not have an Insurance Card you **must provide** the following information in the blocks above in order to process a claim for payment.
-Insurance Company Name - Insurance Phone # - Policy Holder Name - DOB
-Social Security #

Dental Insurance Primary _____

Policy Holder Name:

_____
Date of Birth: _____
SS#: _____
Insurance Company: _____
Member # or ID #: _____
(Located on your insurance card)
Group # _____
Phone # _____

Dental Insurance Secondary _____

Policy Holder Name:

_____
_
Date of Birth: _____
SS#: _____
Insurance Company: _____
Member # or ID #: _____
(Located on your insurance card)
Group # _____
Phone # _____

Medical Insurance Primary _____

Policy Holder Name:

_____
Date of Birth: _____
SS#: _____
Insurance Company: _____
Member # or ID #: _____
(Located on your insurance card)
Group # _____
Phone # _____

Medical Insurance Secondary _____

Policy Holder Name:

_____
Date of Birth: _____
SS#: _____
Insurance Company: _____
Member # or ID #: _____
(Located on your insurance card)
Group # _____
Phone # _____

I understand and agree that I and the Responsible Person signing below are responsible for payment of my bills. I authorize Dr. Michael B Lee D.D.S. to submit claims to my dental and health insurance plans. I understand and agree that I am responsible for all coinsurance, deductible and non-covered services.

I consent to the use or disclosure of my protected health information and any other information about me for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations. This includes disclosure of information to other health care providers referred or consulted for my care, to health insurance plans and to other engaged in health care operations.

I understand the information contained in these forms or otherwise given to Dr. Michael B Lee D.D.S. will be used in submitting claims for payment and I certify that such information is correct. I authorize a copy of this form to be used in place of the original, and the use of "signature on file" on all claims submission. I understand that I am responsible for notifying Dr. Michael B Lee, D.D.S. of any pre-certifications or referrals required by my health plans. I also understand that it will be **my responsibility not that of Dr. Michael B. Lee D.D.S, to confirm any contractual network affiliation with my insurance company.**

Patient/Legal Representative Signature

_____ **Date:** _____