Fereshteh P. Taba, D. D. S., P. A.
12420 San Jose Blvd
Jacksonville, FL, 32223

Insurance Coverage

Primary Dental Coverage

Insurance Company: ____

Subscriber's Name: ____________________________ Subscriber's DOB: _______________

Subscriber's ID or SSN: ____

Subscriber's Employer: ____

Secondary Dental Coverage

Insurance Company:

____

Subscriber's Name: ____________________________ Subscriber's DOB: _______________

Subscriber's ID or SSN:

____

Subscriber's Employer: ____

*Please be aware that there may be a non-duplication rule with respect to your secondary insurance.

By signing below, I understand that:

- The above information is accurate to the best of my knowledge.
- My insurance coverage constitutes a contract between my insurance company and myself. The doctor's office will simply file claims on my behalf.
- I am aware that some of the services provided may be not be covered by my insurance. It is my responsibility to know what procedures my plan covers.
- Insurance payments quoted by the office are only an estimation of benefits. Final determination of benefits are determined by my insurance coverage when claims are received and processed.
- I am financially responsible for any balance due regardless of my dental insurance.
- I authorize the release of any dental or other information necessary to process insurance claims.
- I authorize my insurance benefits to be paid directly to the doctor.

______________________________________ ____________________

Patient Signature (Parent if patient is a minor) Date