

John D. Welch, DDS, LLC
2556 Apple Valley Road
Suite 150
Atlanta, GA 30319

Dental Insurance Coverage

Patient Name: _____ Date of Birth _____

As a courtesy to our patients, we will file your insurance claims on your behalf. All insurance information must be COMPLETE and up to date if insurance is to be billed for you. Our office does not confirm insurance eligibility or coverage, thus we are unable to guarantee the accuracy of the patient's financial responsibility. The patient is responsible for any balance not covered by their insurance. It is the patient's responsibility to check on their insurance coverage prior the appointment.

*****Please note: We do not file COBRA claims*****

Please check one of the following:

_____ I have dental insurance and wish to file any claims myself. I also wish to pay in full at the time of service.

Or

_____ I have dental insurance and I want to pay in full at the time of service. Please file my insurance claim for me and have the check sent to my home.

Or

_____ Please file my dental insurance claim and have the benefit payment sent to the dental office. I agree to pay half of the full fee at the time of service. *I am providing a copy of my Credit Card information to be billed if insurance does not pay the remaining balance due.*

Insurance Card / Policy Holder Information:

Please provide this office with a current copy of your insurance card for verification purposes.

Policy Holder Name: _____ Spouse Parent Other

Group # _____ SS# _____ Date of Birth _____

Employer Name: _____

If a copy of your insurance card has been provided, you do not need to fill out the following:

Insurance Company Name _____

Address _____

ID # _____

Phone # _____