Charles Wallace, DDS, PS
Pamela Solhaug, DDS

3221 Eastlake Ave E #130
Seattle, WA 98102
206-633-5100

Insurance Information

Name of Subscriber:______________________________Date of Birth:__________

Address:___________________________City/State/Zip:______________________

Home phone:_____________Work phone:_____________ID#__________________

Employed by:____

Your relationship to the insured:_______________________________________

If patient is a minor, name and address of responsible party for payment:__________

____Relationship:__________

Dental Insurance Company Name:______________________________

Address:___________________________City/State/Zip:______________________

Phone #:_______________________________________Group #:_______________

Do you have secondary coverage? Yes______No____ Company Name:______________

Address:_______________________________________City/State/Zip:__________

Subscriber Name:___________________Date of Birth:_________ID#______________

Group #:_____________________

Coverage

Preventive____________________ Cal. Year______________________________
Basic_________________________ Deductible_____________________________
Major_________________________ Maximum______________________________
Ortho_________________________ Other________________________________

ASSIGNMENT & RELEASE: I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due. I also authorize the dentist to release any information required for this claim.

Signature:____**Date:**________________

I hereby certify that the above information is correct. I understand that insurance may not cover all costs of treatment and I agree to pay my balance, 1.5% interest/month, and/or all costs of collection insured by Dr. Wallace & Dr. Solhaug. A $65.00 fee is charged for appointments cancelled or broken without 2-business days notice.

Signature:____**Date:**________________