Dr. Mark R. Pasternak, D.M.D.
Inverness Family Dentistry
125 Inverness Drive East, STE 230
Englewood, CO 80112

INSURANCE INFORMATION

Date: _____
Patient Name: _____

Insured Name: _____ DOB_____ SSN/ID# _____
Insurance Company_____ Insurance Phone#_____
Address_____ City/State_____ Zip_____
Employer Name
_____Group#_____

Secondary Carrier:
Insurance Company_____ Insurance Phone_____
Address_____ State_____ Zip_____
Insured
Name_____DOB_____SSN#_____
Employer
Name_____Group#_____

RELEASE & ASSIGNMENT

I hereby authorize Mark R. Pasternak, D.M.D. to release to your company or its representative, any information and/or records of any treatment or examination rendered to me. ***I understand that I am responsible for all charges whether or not paid by insurance. All unpaid balances will accrue interest at the rate of 1.5% per month (18% APR). In the event that collection efforts become necessary, I shall be responsible for all costs of collection, attorney's fees, and court costs. I also authorize and request my Insurance to pay directly to Dr. Mark R. Pasternak D.M.D. my pending claim for services rendered:***

(Patient Signature/Parent Signature) X _____

(Witness Signature) X_____