Patient(s) Name(s):_____

_____

Dental Insurance Information

Primary Insurance
Insured's Name _____
Relationship _____
Birth date _____ SS# _____
Employer_____ How Long? _____
Insurance Co _____
Group # _____
Employee/ Subscriber ID # _____
Claims Address_____
City _____ State _____ Zip_____
Ins Co Phone # _____
Payor/Electronic ID: _____

Secondary Insurance
Insured's Name _____
Relationship _____
Birth date _____ SS# _____
Employer_____ How Long? _____
Insurance Co _____
Group # _____
Employee/ Subscriber ID # _____
Claims Address_____
City _____ State _____ Zip_____
Ins Co Phone # _____
Payor/Electronic ID: _____

Authorization and Release

I agree that I am responsible for all charges for dental services and materials not paid by my dental plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to the use and disclosure of my child's protected health information to carry out payment activities in connection with insurance claims. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the treating dentist or dental entity.

Signature of Primary Insured: _____ Date _____

Signature of Secondary Insured: _____ Date _____