



Patient(s): _____

Dental Insurance Information

Primary Insurance

Secondary Insurance

Insured's Name _____
Relationship _____
Birthdate _____ SS# _____
Employer _____ How Long? _____
Occupation _____
Insurance Co _____
Group# _____
Employee/Subscriber ID # _____
Claims Address _____
City _____ State _____ Zip _____
Ins Co Phone # _____

Insured's Name _____
Relationship _____
Birthdate _____ SS# _____
Employer _____ How Long? _____
Occupation _____
Insurance Co _____
Group# _____
Employee/Subscriber ID# _____
Claims Address _____
City _____ State _____ Zip _____
Ins Co Phone# _____

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.

_____ **Date** _____
Signature of Primary Insured

_____ **Date** _____
Signature of Secondary Insured