Patient(s):_______________________________________

Dental Insurance Information

Primary Insurance

Insured's Name________________________________
Relationship__________________________________
Birthdate______________SS#____________________
Employer________________________How Long?_____
Work Phone____________________________________
Insurance Co__________________________________
Group#____
Employee/Subscriber ID #______________________
Claims Address________________________________
City____________________State_____Zip_________
Ins Co Phone #________________________________

Secondary Insurance

Insured's Name________________________________
Relationship__________________________________
Birthdate______________SS#____________________
Employer________________________How Long?_____
Work Phone____________________________________
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