

Primary Dental Insurance _____

Insurance address _____

Name of Insured _____

Relationship to patient _____

Social Security number of insured _____

Date of Birth _____

Group Number _____

Employer _____

Additional Insurance

Dental Insurance Company _____

Address of Company _____

Relationship to patient _____

Social Security number of insured _____

Date of Birth _____

Group Number _____

Employer _____

Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such care to third party payers and/or healthcare practitioners.

I authorize and request any insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date: _____
Signature of patient or parent if a minor