INSURANCE INFORMATION

Name of Insured:_____ Relationship:_____

Birth date:_____ Soc. Sec # _____ Date Employed:_____

Employer:_____ Work Phone:_____

Address of Employer _____
Street City State Zip

Insurance company:_____ Group #:_____ Employer/cert. #_____

Ins. Co. address:_____ How much is your deductible?:_____

How much have you used this year?:_____ Max annual benefit?:_____

Do you have secondary insurance? ❑Yes ❑No If yes, complete the following:

Name of Insured:_____ Relationship:_____

Birthdate:_____ Soc. Sec # _____ Date Employed:_____

Employer:_____ Work Phone:_____

Address of Employer _____
Street City State Zip

Insurance company:_____ Group #:_____ Employer/cert. #_____

Ins. Co. address:_____ How much is your deductible?:_____

SIGNATURE ON FILE

By signing below, I agree to the following, and that my authorization will remain in effect until revoked or rescinded.

- I authorize use of this form on all my insurance submissions.
- I authorize the office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent children during the period of such dental care to third party payers and/or health practitioners.
- I authorize release of information to all my insurance companies.
- I understand that my dental 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 on behalf of my dependents.
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
- I authorize payment directly to my doctor.
- I permit a copy of this authorization to be used in place of the original.
- I authorize the use of this form for my dependent children.

_____ _____ _____
Print name Signature Date