Dental Insurance Information

Primary Insurance

Name of Insured_____

Relationship to patient_____

Insured's birthdate_____

SS#/SIN_____

Employer_____

Date Employed_____

Occupation_____

Insurance Company_____

Group #_____

Employee/Cert #_____

Ins. Co. Address_____

Deductible_____

Amount already used_____

Max. annual benefit_____

Additional Insurance

Name of Insured_____

Relationship to patient_____

Insured's birthdate_____

SS#/SIN_____

Employer_____

Date Employed_____

Occupation_____

Insurance Company_____

Group #_____

Employee/Cert #_____

Ins. Co. Address_____

Deductible_____

Amount already used_____

Max. annual benefit_____

Authorization and Release

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

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

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 my dependents.

X_____

Signature of patient or parent/guardian if minor Date