IF YOU HAVE DENTAL INSURANCE, YOU MUST COMPLETE ALL THE FOLLOWING INFORMATION

PRIMARY DENTAL INSURANCE COVERAGE

NAME OF INSURANCE CO. _____

ADDRESS TO SEND INSURANCE CLAIMS: _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____

NAME OF INSURED SUBSCRIBER _____

PLEASE CIRCLE RELATIONSHIP OF PATIENT TO SUBSCRIBER: SELF SPOUSE CHILD

POLICY/GROUP NUMBER _____ INSURED SS# _____

WHEN WAS THE LAST TIME YOUR INSURANCE BENEFITS WERE UPDATED? _____

WHAT MONTH DID YOUR BENEFITS RENEW FOR ANOTHER CALENDAR YEAR? _____ DATE OF BENEFIT RENEWAL _____

IF YOU HAVE SECONDARY DENTAL INSURANCE, PLEASE COMPLETE ALL THE FOLLOWING INFORMATION

SECONDARY DENTAL INSURANCE COVERAGE

NAME OF INSURANCE CO. _____

ADDRESS TO SEND INSURANCE CLAIMS: _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____

NAME OF INSURED SUBSCRIBER _____

PLEASE CIRCLE RELATIONSHIP OF PATIENT TO SUBSCRIBER: SELF SPOUSE CHILD

POLICY/GROUP NUMBER _____ INSURED SS# _____

WHEN WAS THE LAST TIME YOUR INSURANCE BENEFITS WERE UPDATED? _____

WHAT MONTH DID YOUR BENEFITS RENEW FOR ANOTHER CALENDAR YEAR? _____ DATE OF BENEFIT RENEWAL _____

SIGNATURE ON FILE

_____ is authorized to provide any insurance company(s), claim administrator(s) and consulting health care professionals, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits. This authorization is valid for the term of coverage of the policy or contract, in force on this date only. I know I have a right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

_____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE DATE

I hereby authorize payment directly to _____ of the dental benefits otherwise payable to me.

_____

GUARANTOR'S SIGNATURE (Person responsible for this account) DATE

INSURANCE/SIGNATURE ON FILE

PATIENT SIGNATURE

(Person being seen for the visit)

PATIENT'S NAME _____

Last First Initial

_____

ATTENDING D.D.S. NAME

is authorized to provide any insurance company(s), claim administrator(s) and consulting health care professionals, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits. This authorization is valid for the term of coverage of the policy or contract, in force on this date only, or for two years, whichever is shorter. I know I have a right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

_____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE DATE

GUARANTOR SIGNATURE

(Person responsible for this account)

I hereby authorize payment directly to _____ of the dental benefits otherwise payable to me.

_____

GUARANTOR'S (INSURED) SIGNATURE DATE

SIGNATURE ON FILE