INSURANCE INFORMATION

Patient Name: ____ **Patient Birthdate:** ____/____/____

Primary Insurance Dental Coverage? Yes ___ No ___ Orthodontic Coverage? Yes___ No ___

Insurance Co. Name: _____________________________________ Phone #: (____)___________________

Insurance Co. Address: ____
Street/PO Box City State Zip

Insured's Name: ___________________________________Insured's Social Security #: _____-_____-_____

Insured's Birthdate: ____/____/____ Relationship to Patient: _________________ Group #: ______________

Insured's Employer: _______________________________________ Phone #: (____)__________________

Employer's Address: ____
Street/PO Box City State Zip

Secondary Insurance Dental Coverage? Yes ___ No ___ Orthodontic Coverage? Yes___ No ___

Insurance Co. Name: ______________________________________ Phone #: (____)___________________

Insurance Co. Address: ____
Street/PO Box City State Zip

Insured's Name: ___________________________________ Insured's Social Security #: _____-_____-_____

Insured's Birthdate: ____/____/____ Relationship to Patient: _________________ Group #: ______________

Insured's Employer: ____ Phone #: (____)_________________

Employer's Address: ____
Street/PO Box City State Zip

RELEASE /STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO PROVIDER

I, (We), the undersigned patient and/or responsible party hereby jointly authorize this office, its agents/employees to release and disclose all or any part of the patient's dental records to any entity which is, or may be liable, for all or part of the provider charges.

I, (We), authorize the release and disclosure of any and all of my dental records to any other entity, including, but not limited to, referring physicians, hospitals, or other health care providers, which may be of assistance in the opinion of this office, in providing for the treatment of the patient.

I, (We), authorize the release of records necessary to assist in the reimbursement of benefits to which I, (We) may be entitled. I, (We) authorize this office and/or its employees to release via fax machine, dental records which are needed in order to provide patient with the most appropriate medical care.

I, (We), authorize and request that payment of any third party or insurance company benefits be made to this office for any services furnished to patient. The signatures furnished below shall suffice for all insurance forms on a continuing basis.

____ ____
Signature of Patient/Guardian Date Signature of Insured Date