Insurance Information:

Primary Insurance (Circle) Medical•Dental

Name of Insured _____

Relationship _____

Insured's Birthdate _____

Social Sec # _____

Employer _____

Employer Address _____

Benefit Plan Name: _____

Insurance Company _____

Ins Co. Address _____

Group # _____

Telephone # _____

Additional Insurance (Circle) Medical•Dental

Name of Insured _____

Relationship _____

Insured's Birthdate: _____

Social Sec # _____

Employer _____

Employer Address _____

Benefit Plan Name: _____

Insurance Company _____

Ins Co. Address _____

Group # _____

Telephone # _____

Authorization and Release

I authorize the release of 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 insurance benefits otherwise payable to me.

I agree that should the amount paid by the insurance company not cover the entire expense, I will be responsible for payment of the difference. If the expense is not covered by the policy, I am responsible for payment of the entire bill.

_____

Signature of responsible party Relationship Date