Dental Benefit Plan / Dental Insurance Information

Are you enrolled in a dental benefit plan or dental insurance plan? Yes ____ No ____

Please complete the following information

Primary Plan / Insurance

Name of Insured: _____

Social Security Number: _____

Employer: _____

Employer Address:

_____

_____

Insurance Company: _____

Group Number: _____

Secondary Plan / Insurance □ None

Name of Insured: _____

Social Security Number: _____

Employer: _____

Employer Address:

_____

_____

Insurance Company: _____

Group Number: _____

Dental Benefit/Insurance Authorization and Release

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

Signature of patient/parent Date