Dental Insurance Information

Patient _____

Primary Subscriber		Secondary Subscriber	
Name	Birthdate	Name	Birthdate
Soc. Sec. #	Relationship	Soc. Sec. #	Relationship
Employer		**Employer**	
Name		Name	
Address		Address	
City	State Zip	City	State Zip
Telephone Number		Telephone Number	
Dental Insurance Company		**Dental Insurance Company**	
Name		Name	
Address		Address	
City	State Zip	City	State Zip
Telephone Number		Telephone Number	
Group Number		Group Number	
Subscriber ID#	Effective Date	Subscriber ID#	Effective Date

Authorization for Submission of Claims and Assignment of Benefits

I authorize Children's Dental Clinic to submit claims for payment of services to the Insurance companies named above in my behalf. I hereby authorize payment of dental benefits otherwise payable to me directly to the above named dental provider.

_____ _____

Signed (Employee / Subscriber) Date

Authorization for Release of Information

I authorize Children's Dental Clinic to provide any insurance company(s), administrator(s) or health care professionals with health care advice, radiographs or treatment provided to be used for the purpose of evaluating and administrating claims for benefits.

_____ _____

Signed (Employee / Subscriber) Date