INSURANCE INFORMATION

Name of insured _____ SS # _____

Birthdate _____ Relationship to patient _____

Employer _____ Date employed _____

Do you have additional dental insurance? If yes, fill out following.

Name of insured _____ SS # _____

Birthdate _____ Relationship to patient _____

Employer _____ Date employed _____

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.	I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.
Signed (Patient or parent if minor)	Signed (Insured person)

Please Advise Us Immediately Of Any Changes With Your Dental Insurance.

712-585-3802