

DENTAL INSURANCE INFORMATION

Primary Insurance

Subscriber Name _____ Social Security # _____ - _____ - _____ Birthdate _____

Employer _____ Phone# _____

Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group# _____

Address _____ City _____ State _____ Zip _____

Phone #(_____) _____ - _____

Covered Dependents

Name _____ Relationship _____ Birthdate _____

Name _____ Relationship _____ Birthdate _____

Name _____ Relationship _____ Birthdate _____

Additional Insurance

Subscriber Name _____ Social Security # _____ - _____ - _____ Birthdate _____

Employer _____ Phone# _____

Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group# _____

Address _____ City _____ State _____ Zip _____

Phone #(_____) _____ - _____

Covered Dependents

Name _____ Relationship _____ Birthdate _____

Name _____ Relationship _____ Birthdate _____

Name _____ Relationship _____ Birthdate _____

The undersigned, hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself/and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will bound by this signature as though the undersigned had personally signed the particular claim.

Authorized Signature of Covered Person/Employee

Date

