Insurance Information

Name of Policyholder_____ Birthdate_____

SSN#_____ Work#_____ Home#_____ Cell#_____

Employer's Name_____ Date of Employment_____

Insurance Company_____ Employee ID#_____ Group#_____

Policyholder's Relationship to Patient_____

Authorization, Release, and Agreement to pay for Services Rendered

I authorize the dentist to release any information including diagnosis and records of any treatment or examination rendered to me during the period of such dental care to third party payors and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual fee for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

_____ _____

Signature of Responsible Party Date