Insurance Information

Name of Insured

Telephone (Home) Telephone (Work)

Social Security No.

Birth Date of Insured

Address

City State Zip Code

E-mail

Occupation of Insured

Insured Employer

Telephone (Employer)

Address

City State Zip Code

Insurance Coverage

Insurance Company Name

Address

City State Zip Code

Telephone

Group No.

ID. No.

I have reviewed the treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

▶

Signed (Patient, or parent if Minor)

Date

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

▶

Signed (Insured person)

Date
