# INSURANCE INFORMATION

*(Please Print)*

Date: ______________________________ Patient ID: __________________

Patient Name: ______________________________ D.O.B.: ____________________

Subscribers Name: ____________________________ D.O.B.: ______________________

Employed By: ____________________________________________________________

Business Address: __________________________________________________________

Business Phone: ______________________ Social Security No.: ____________________

Insurance Company: __________________________________________________________

Subscriber No.:_____________________ Group No.: ____________________________

*Is the patient covered by a secondary insurance? Yes / No*

Insurance Co.: ____________________________________________________________

Secondary Subscribers Name: _________________________________________________

Secondary Social Security No.: _________________________ D.O.B.: ______________

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**AUTHORIZATION TO RELEASE INFORMATION** - I hereby authorize any Dentist, Physician, Hospital, Pharmacy, Insurance Company, Employer or Organization to release any information regarding the medical or dental history, treatment or benefits payable for this claim to The Plan Administrator or its authorized agent for the purpose of validating and determining benefits payable in connection with this claim. Data may be extracted for statistical, audit and verification purposes. I understand that I may request to receive a copy of this authorization:

______________________________________________________________________________

Signature Print Date

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**AUTHORIZATION TO PAY BENEFITS TO DENTIST** – I hereby authorize payment directly to the above named Dentist of the Dental Benefits otherwise payable to me.

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Signature Print Date

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**CERTIFICATION** – I certify that the foregoing information is true and correct.

______________________________________________________________________________

Signature Print Date