PATIENT INSURANCE INFORMATION

COVERED PERSON:

Full Name: ______________________________ Birthdate: ______________ (mo day year)

Address: ______________________________ **Soc. Sec. No.:** ______________

City, State, Zip: ______________________________ Phone: ______________

Employer: ______________________________ Phone: ______________

Address: ______________________________

Insurance Carrier Name and Address: ______________________________

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Group Name and/or Number: ______________________________

Does this plan cover all family members? ______ Yes ______ No

If not, specify those not covered: ______________________________

SPOUSE:

Full Name: ______________________________ Birthdate: ______________ (mo day year)

Soc. Sec. No.: ______________ Is spouse employed? ______ Yes ________No

If yes, Employer: ______________________________ Phone: ______________

Address: ______________________________

Does spouse have other dental insurance coverage? ______ Yes ________No

If yes, Insurance Carrier Name and Address: ______________________________

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Group Name and/or Number: ______________________________

Does this plan cover all family members? ______ Yes ________No

If not, specify those not covered: ______________________________

DEPENDENT CHILDREN:

Full Name: ______________________________ Birthdate: ______________ (mo day year)

Full Time College Student, School Name: ______________________________ City: ______________

Full Name: ______________________________ Birthdate: ______________ (mo day year)

Full Time College Student, School Name: ______________________________ City: ______________

Full Name: ______________________________ Birthdate: ______________ (mo day year)

Full Time College Student, School Name: ______________________________ City: ______________

Full Name: ______________________________ Birthdate: ______________ (mo day year)

Full Time College Student, School Name: ______________________________ City: ______________

List additional dependents on reverse.

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

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Authorized Signature of Covered Person / Employee Date

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Authorized Signature of Covered Person / Employee Date