INSURANCE INFORMATION/RELEASE AUTHORIZATION

PRIMARY INSURED

Name: _____ Birthdate: _____

Address: _____ Soc. Sec. No. _____

City, State, Zip_____ Carrier Name: _____

Group/Contract#_____ 800# _____

Employer:_____

PLEASE NOTE: UNLESS AN ALTERNATE ID # HAS BEEN ISSUED BY YOUR INSURANCE CARRIER, WE *MUST* HAVE A SOCIAL SECURITY # TO SUBMIT CLAIMS TO YOUR INSURANCE CARRIER.

SECONDARY INSURED

Name: _____ Birthdate: _____

Address: _____ Soc. Sec. No. _____

City, State, Zip_____ Carrier Name: _____

Group/Contract#_____ 800# _____

Employer:_____

DEPENDENT CHILDREN

Name: _____ Birthdate: _____

Full Time College Student: School Name, Address: _____

Name: _____ Birthdate: _____

Full Time College Student: School Name, Address: _____

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 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.

_____ _____

Authorized Signature of Covered Person/Employee Date