# Dental Insurance Information

For our patients with dental insurance, please complete the following information.

Patient's Name _____
Last First Middle

Patient's Birth Date_____ Male Female Relationship to Insured _____ Patient ID # _____

Insured's Name _____
Last First Middle

Insured's SS# _____ Insured ID # _____ Insured's Birth Date _____

Dental Insurance Company Name _____
Name

Insured's Employer _____

Employer's Address _____

Group # _____ Do you have dual coverage? Yes No If yes, please complete the following:

Insured's Name_____
Last First Middle

Insured's Address _____
Street City State Zip

Insured's SS# _____Insured ID #_____ Insured's Birth Date _____

Patient ID# _____

Dental Insurance Company Name _____
Name

Insured's Employer _____

Employer's Address_____

Group # _____

**INSURANCE RELEASE AND/OR ASSIGNMENT OF BENEFITS.**

**If you request assignment of benefits please sign. After reviewing my treatment plan, I authorize release of any information relating to this claim. I understand that I am responsible for all of the cost of my dental treatment. I hereby authorize payment of group insurance benefits to the dentist who provided my treatment, otherwise payable to me.**

_____ _____
**Signature of Patient or Guardian** **Date**