Dental Insurance Information

Policy Holder _____ Birth date _____

Relationship to patient _____ Employer _____

Policy ID # _____ Group # _____

Insurance Company _____ Address _____

Policy Holder _____ Birth date _____

Relationship to patient _____ Employer _____

Policy ID # _____ Group # _____

Insurance Company _____ Address _____

I authorize and request my insurance company to pay directly to the office all insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____

Signature of patient or responsible party and date