# Dental Insurance

## Primary Dental Insurance:

Name of Main Policy Holder________________________________________ Birth Date_____________

Social Security Number of Main Policy Holder________________________________________________

Please list all family members/ dependents covered under this policy who may be seen at this office, their relationship to the main policy holder (spouse, son daughter, etc.) and their birth dates.

| NAME | RELATIONSHIP | BIRTH DATE |
|---|---|---|
| 1) ______________________________ | __________________________ | _____________ |
| 2)______________________________ | __________________________ | _____________ |
| 3)______________________________ | __________________________ | _____________ |
| 4)______________________________ | __________________________ | _____________ |
| 5)______________________________ | __________________________ | _____________ |
| 6)______________________________ | __________________________ | _____________ |
| 7)______________________________ | __________________________ | _____________ |
| 8)______________________________ | __________________________ | _____________ |

Insurance Company Name_______________________________________________________________

Address to send Insurance Claims__________________________________________________________

Group Number_____________________________

Do you have secondary dental insurance coverage? Y N

I authorize the release of any information concerning my (or my dependent's) dental care, advice, and treatment provided for the purpose of evaluating and administering claims for dental insurance benefits.

I hereby authorize payment of said dental insurance benefits directly to the dentist otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of services not paid, in whole or in part, by my dental insurance.

Date________________ Signature________________________________________________________