BENEFIT INFORMATION

Primary

Name of Insured: _____ is insured a patient? _____
(Last, First, MI)

Insured's Birth Date: _____ ID# _____ Group #: _____

Insured's Address: _____
(Street, City, State, Zip code)

Patient's relationship to insured: _____

Benefit plan name and address: _____

Secondary

Name of insured: _____ is insured a patient? _____
(Last, First, MI)

Insured's Birth Date: _____ ID# _____ Group #: _____

Insured's Address: _____
(Street, City, State, Zip code)

Patient's relationship to insured: _____

Benefit plan name and address: _____

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits 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 all services rendered on my behalf or my dependents in full at the time of services unless other agreements have been made. I also understand that I am responsible for all additional charges that may transpire such late fees and fees for appointments missed without 24-hour notice. I agree to reimburse the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

I have read and understand your Notice of Privacy Practices.

X_____ Date_____
Signature of patient of parent/guardian if minor