Patient Information	Dental Insurance
Date:	Primary Insurance:
Last Name, First Name Middle Initial	ID Number: Group Number:
Date of Birth:	SSN:
Marital Status:	Who is Responsible for this Account? Date of Birth:
Street Address:	Is the patient covered by additional Insurance?
City, State, Zip	Secondary Insurance:
Email:	ID Number Group Number
Patients Employer: Phone Number:	Who is responsible for this account? Date Of Birth:

Assignment and Release

I certify that I, and or my dependent(s), have insurance with_____ and are assigned directly to Dr._____, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges weather not paid by insurance. I authorize the use of my signature on all insurance submissions.

They above-named dentist may use my health care information and may disclose such information to the above names insurance company(ies), and their agents for the purpose of obtaining payment for services and the determination of insurance benefits of the benefits payable for related services. The consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian, or Personal Representative

Please print name of Patient, Parent, Guardian, or Personal Representative