youngdentistry FOR CHILDREN

Patient(s):_____

Dental Insurance Information

Primary Insurance

Insured's Name_____
Relationship_____
Birthdate_____SS#_____
Employer_____How Long?____
Work Phone_____
Insurance Co_____
Group#_____
Employee/Subscriber ID #_____
Claims Address_____
City_____State_____Zip_____
Ins Co Phone #_____

Secondary Insurance

Insured's Name_____
Relationship_____
Birthdate_____SS#_____
Employer_____How Long?____
Work Phone_____
Insurance Co_____
Group#_____
Employee/Subscriber ID#_____
Claims Address_____
City_____State_____Zip_____
Ins Co Phone#_____

Authorization and Release

I agree that I am responsible for all charges for dental services and materials not paid by my dental plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to the use and disclosure of my child's protected health information to carry out payment activities in connection with insurance claims. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the treating dentist or dental entity.

_____ **Date** _____
Signature of Primary Insured

_____ **Date**_____
Signature of Secondary Insured