youngdentistry
FOR CHILDREN

Primary Insurance

Policy Holder _____

Relation to patient_____

Birthdate _____SS#_____

Employer _____How long?_____

Insurance CO_____

Policy Holder ID#_____

Group #_____

Claims Address_____

City_____State_____Zip_____

Ins Co Phone#_____

Secondary Insurance

Policy Holder _____

Relation to patient_____

Birthdate _____SS#_____

Employer _____How long?_____

Insurance CO_____

Policy Holder ID#_____

Group #_____

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 .This authorization is valid for all dependents listed on my account unless otherwise stated. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the treating dentist or dental entity. This authorization is valid for this and all dental plans used for services with Young Dentistry for Children regardless of policy holder changes. It will be my responsibility to provide up to date and accurate dental insurance information prior to all visits.

_____ _____ _____

Primary Insured name (printed) Primary Insured name (signature) Date

_____ _____ _____

Secondary Insured name (printed) Secondary Insured name (signature) Date