SIGNATURE ON FILE

Please complete for group or private dental insurance. If the patient is covered by Medicaid only, you do not need to complete this form.

PRIMARY DENTAL INSURANCE

Subscribers Name____Birth Date______________________

Street Address____SS#___________________________

City, State, Zip____Relationship to Child______________

Employer____

Insurance Company Name____

Insurance Address and Phone____

ID #____Group #_______________________

SECONDARY DENTAL INSURANCE

Subscribers Name____Birth Date______________________

Street Address____SS#___________________________

City, State, Zip____Relationship to Child______________

Employer____

Insurance Company____

Insurance Address and Phone ____

ID #____Group #_______________________

COORDINATION OF BENEFITS INFORMATION: If a patient is eligible for coverage under two or more dental care programs, the primary insurance is determined by the birthdate of the subscribers unless designated by divorce decree or guardianship papers.

Dependent Children's Names	Birthdate	Primary	Secondary	Both

The undersigned, hereby authorizes the release of any information relating to all claims for benefits on behalf of the above named dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims or benefits, for services rendered without obtaining my signature on each and every claim for my dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I understand that it is my responsibility to inform the dental office of any changes which affect the above information.

Signature____Date____________________