Secondary Insurance:

Name_____ Date of Birth ____/____/_____

Address_____

City_____ State _____Zip Code_____

Employer _____

Dental Ins Co _____

Subscriber ID # _____ Group # _____

Emergency Contact

Name _____ Relation: _____

Address_____

City _____ State _____ Zip Code _____

Phone Number _____

Authorization

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for the cost of all dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

Sign (Parent or Responsible Party) _____

Date _____/_____/_____