PATIENT NUMBER

© 1991 Wisconsin Dental Association
(800) 243-4675

PATIENT'S NAME _____
Last First Initial

I hereby authorize payment directly to PEDIATRIC DENTAL GROUP
of the dental benefits otherwise payable to me. (DENTIST'S NAME)

_____
SIGNATURE (INSURED PERSON)

_____
DATE

Signature is valid for two years from the above date, unless revoked by me at an earlier date.

PEDIATRIC DENTAL GROUP
ATTENDING D.D.S. NAME

is authorized to provide any insurance company(s), claim administrator (s) and consulting health care professionals, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits.

This authorization is valid for the term of coverage of the policy or contract, in force on this date only, or for two years, which ever is shorter.

I know I have a right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

PATIENT OR AUTHORIZED PERSON'S SIGNATURE DATE

Form 250SF

SIGNATURE ON FILE