



ONLY WRITE INSURANCE INFORMATION  
NEXT TO THE POLICY HOLDER, BELOW.

**ACCOUNT HOLDER:** Hm Phone: \_\_\_\_\_

Bus Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Maiden Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State & Zip: \_\_\_\_\_

Employer: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Soc. Sec. No.: \_\_\_\_\_

Carrier Name: \_\_\_\_\_

Group/Contract No.: \_\_\_\_\_

**SPOUSE:** Hm Phone: \_\_\_\_\_

Bus Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State: \_\_\_\_\_

Employer: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Soc. Sec. No.: \_\_\_\_\_

Carrier Name: \_\_\_\_\_

Group/Contract No.: \_\_\_\_\_

**DEPENDENT CHILDREN (or full time student)**

Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ M F

Full Time College Student: School Name: \_\_\_\_\_ City: \_\_\_\_\_

Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ M F

Full Time College Student: School Name: \_\_\_\_\_ City: \_\_\_\_\_

Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ M F

Full Time College Student: School Name: \_\_\_\_\_ City: \_\_\_\_\_

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I acknowledge that my signature on this document authorizes the dentist to submit claims for benefits applied to services rendered, without obtaining my signature on each and every claim. I understand that I will be responsible for whatever part of the dentist's fee for services rendered that are not covered by my/our insurance, including any/all costs of collection. I further understand there will be a service charge of 1.5% per month or 18% per annum on any account balance over sixty days old, whether or not insurance benefits have been paid.

\_\_\_\_\_  
Authorized Signature of Covered Person/Employee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Signature of Covered Person/Employee

\_\_\_\_\_  
Date

**NOTIFY IN CASE OF EMERGENCY OTHER THAN SPOUSE**

Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_ Relation: \_\_\_\_\_