Employment Information

Insured Employer Name: _____ Occupation: _____

Employer Address: _____

Phone:( ) _____ Ext _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Y ____ N ____

Insured Social Security # _____Insured Birth Date: _____

Insurance Plan Name: _____

ID#: _____ Group #: _____

Secondary

Name of Insured: _____ Is insured a patient? Y ____ N ____

Insured Social Security # _____Insured Birth Date: _____

Insurance Plan Name: _____

ID#: _____ Group #: _____

Consent for Services

So you don't have to sign an insurance form at each dental visit, Dr. Paul M. Hoppe and Dr. Vanessa G. Cruz, will maintain this "signature on file" for you.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize my provider, insurer or organization to release any information regarding the dental history, treatment, or benefits payable for this claim of the Plan Administrator or its authorized agent for the purpose of determining benefits payable.

Signature: **X**_____ Date: _____

AUTHORIZATION TO PAY BENEFITS TO ABOVE NAMED DENTIST: I hereby authorize payment directly to High Park Dental for services rendered.

Signature: **X**_____ Date: _____

(FOR OFFICE USE ONLY)

Rep Name: _____ Waiting Periods _____ FMX/pano_____ Prophy/4910 _____ Fl tx_____

Exam _____Max _____Available _____ Effective date_____ Renewal date_____

Ded. _____ Waived on P _____ Preventative _____Basic _____ Major _____

NG _____ Post comp _____BU:_____ Prior extractions:_____ Implant:_____

Replacement C&B/dentures_____ PPO Providers _____ E-claims _____