DENTAL INSURANCE AUTHORIZATION FORM

PATIENT INFORMATION

Patient Name
First MI Last Sex Male Female

Patient's Birthdate Patient's SS# If patient is a full time student, name of school:

PRIMARY DENTAL INSURANCE INFORMATION

Employee's Name
First MI Last

Employee's SS#

Employee's Birthdate

Employer's Name & Address

Name & Address of Insurance Company

Group #

Relationship to Patient

___Self ___Spouse

___Parent ___Other

SECONDARY DENTAL INSURANCE INFORMATION

Is the patient covered by a secondary dental insurance plan?___Yes___No

If Yes, complete the following:

Employee's Name
First MI Last

Employee's SS#

Employee's Birthdate

Employer's Name & Address

Name & Address of Secondary Insurance Company

Group #

Relationship to Patient

___Self ___Spouse

___Parent ___Other

I agree to be responsible for all charges for dental services not paid by my dental plan, unless the treating dentist or dental practice has a contractual agreement with my plan to write off a portion of the charges. I authorize the disclosure of my protected health information for treatment, payment and healthcare operations and the electronic, paper, fax or verbal transmission of protected health information to a clearinghouse, as well as, to and from my insurance company(ies), its employees and authorized representatives. I authorize the disclosure of my protected health information to my employer and my employer's personnel office for the purpose of processing my insurance claims or verification of coverage relating to my dental treatment and collecting unpaid balances for services rendered.

Signature_____ Date _____

I hereby authorize payment of the dental benefits otherwise payable to me directly to the dentist named herein.

Signature_____ Date_____

Bowling & Dunn Family Dentistry
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