DENTAL INSURANCE INFORMATION

Patient Name: ________________________________ DOB: ___/___/___

Primary Dental Insurance Company Name: ____

Phone #: ________________ Group #: ____________________ ID #:_____________________________

Insurance Company Address: ____

Insured's Name: _________________ Insured's Social Security #: ________ Insured's DOB: ___/___/___

Relationship to patient: __________________ Insured's Employer: ______________________________

Employer's Address: ____

RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS

I authorize the release of any dental information necessary to process this claim and authorize the release of dental benefits to NOVA Pediatric Dentistry & Orthodontics for professional services rendered.

Signature ____ Date _________________________________

Office Use Only: Participating or Non-Participating