DENTAL INSURANCE INFORMATION AND AUTHORIZATION

PRIMARY DENTAL INSURANCE (**insurance in your name or insurance to be filed first**)

Insurance Company Name:____

Insurance Company Address:__________________City, State & Zip__________________

Insurance Company Phone #:____

Name of Policy Holder:_______________________________Date of Birth:________

Group Policy Number:___________________ID# or SS#:______________________

Place of Employment:____

Relationship to Patient:____

SECONDARY DENTAL INSURANCE (**your spouse's insurance or insurance to be filed after the first**)

Insurance Company Name:____

Insurance Company Address:___________________City, State & Zip__________________

Insurance Company Phone #:____

Name of Policy Holder:_______________________________Date of Birth:________

Group Policy Number:_____________________ID# or SS#:_____________________

Place of Employment:____

Relationship to Patient:____

I hereby authorize the release of any pertinent clinical or radiographic information by Dr. Michael J. Brenegan or his staff to the above mentioned insurance company or companies for the purpose of assisting in the processing of my insurance claims.

Signed:____Date:______________________________