

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: _____