INSURANCE INFORMATION

Child's name: _____ Birth Date: _____/_____/_____

PRIMARY INSURANCE: Employee's Date of Birth: _____/_____/_____ Child's relationship to employee: _____

Employee's Name _____ Social Security # _____

Home Address _____ City _____ Zip _____

Name of Insurance Carrier _____ Policy/Group # _____ ID# (If different from SS#)_____

Address to which form should be sent _____

Employer _____ Employer City _____

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Do you have dual coverage? Yes ( ) No ( )

SECONDARY INSURANCE: Employee's Date of Birth: _____/_____/_____ Child's relationship to employee: _____

Employee's Name _____ Social Security # _____

Home Address _____City _____ Zip _____

Name of Insurance Carrier _____ Policy/Group # _____ ID# (if different from SS#)_____

Address to which form should be sent _____

Employer _____ Employer City _____

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CONSENT TO RELEASE INFORMATION:

You are authorized to provide the above-named insurance company, service corporation or trust administrator information concerning care, advice, treatment or supplies provided for the patient for the purpose of evaluating and administering claims for benefits.

The authorization is valid for the term of coverage of the policy or contract under which a claim has been submitted or until payment, or denial o payment, has been received from the company, corporation or administrator.

I agree that a copy of this authorization shall be as valid as the original.

Signed (Primary): _____ Date: _____

Parent or Legal Guardian

Signed (Secondary): _____ Date: _____

I authorize payment directly to Leland Grant, D.D.S. of the dental benefits otherwise payable to me.

Signed (Primary): _____ Date: _____

Insured Person

Signed (Secondary):_____ Date: _____