DENTAL INSURANCE AUTHORIZATIONS

PATIENT Name _____
First Middle Last

PATIENT date of birth _____

Please provide us with a copy of your current DENTAL insurance card or other evidence of coverage. This is for your DENTAL insurance only. We do not file medical insurance claims, and we do not need your medical insurance information. Remember to keep your dental insurance information updated with us when it changes.

Please read, sign, and date BOTH authorizations below:

1. **AUTHORIZATION TO FILE INSURANCE ON YOUR BEHALF:**
   I agree that I am responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with filing any and all claims on my behalf.

   Signature _____ Date _____
   Patient *(parent or guardian, if under 18)*

2. **AUTHORIZATION FOR ASSIGNMENT OF BENEFITS:**
   I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the treating dentist or dental practice.

   Signature _____ Date _____
   Patient *(parent or guardian, if under 18)*