PLEASE COMPLETE THE FOLLOWING INFORMATION

PRIMARY INSURANCE

PATIENT'S NAME: ________________________________GROUP#:____________________

DENTAL INSURANCE: ____

INSURANCE ADDRESS: ____

____

INSURANCE PHONE #:____

INSURED'S SOCIAL SECURITY #: ____

INSURED'S NAME: _____________________________ INSURED'S BIRTHDATE: _________

SECONDARY INSURANCE

PATIENT'S NAME: ________________________________GROUP#:____________________

DENTAL INSURANCE: ____

INSURANCE ADDRESS: ____

____

INSURANCE PHONE #:____

INSURED'S SOCIAL SECURITY #: ____

INSURED'S NAME: _____________________________ INSURED'S BIRTHDATE: _________

I hereby authorize payment of the dental benefits, otherwise payable to me, directly to the below named dental entity.

Print name of insurance subscriber: _______________________________________

X____ Date: _________________

(Signature of insurance subscriber)

Patient's name: ____

Children's Dental Health Center
Stephen S. Berger, DDS