RDA Roeser Dental Associates, P.C.

DENTAL INSURANCE INFORMATION

Patient Name: _____ Date: _____

Subscriber #1:_____ Subscriber #1 Social Security #:_____

Relation to Subscriber #1:_____ Subscriber #1 Birthdate: _____

Employer: _____

Insurance Carrier: _____ Policy/Group #:_____

Subscriber #2:_____ Subscriber #2 Social Security #:_____

Relation to Subscriber #2:_____ Subscriber #2 Birthdate: _____

Employer: _____

Insurance Carrier: _____ Policy/Group #:_____

RELEASE OF DENTAL INSURANCE INFORMATION

I hereby authorize Roeser Dental Associates, P.C. to release any dental information which might be needed in connection with payment for dental services.

_____ _____

Patient/Parent/Guardian Signature Date

AUTHORIZATION TO PAY BENEFITS

I request that payment under my dental insurance program be made to Roeser Dental Associates, P.C. on any services rendered at this office. I understand I am financially responsible to Roeser Dental Associates, P.C. for fees not covered by this authorization.

_____ _____

Patient/Parent/Guardian Signature Date