

FOR PATIENTS COVERED BY DENTAL INSURANCE

Date _____

PRIMARY CARRIER

Subscriber's Full Name _____

Subscriber's DOB _____

Social Security Number _____

ID Number _____

Group Number _____

Employer Name _____

Insurance Company _____

Insurance Mailing Address _____

Insurance Phone Number _____

SECONDARY CARRIER

Subscriber's Full Name _____

Subscriber's DOB _____

Social Security Number _____

ID Number _____

Group Number _____

Employer Name _____

Insurance Company _____

Insurance Mailing Address _____

Insurance Phone Number _____

In order to comply with most insurance companies, we ask that you sign below so that we may keep your signature on file.

I have reviewed the treatment plan.
I authorize release of any information to this claim.

Signed patient or parent (if minor)

I hereby authorize payment directly to Dr. Michael Hansen
of dental insurance benefits otherwise payable to me.

Signed insured person