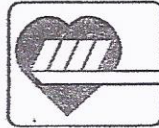


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DENTAL INSURANCE 1ST COVERAGE

EMPLOYEE NAME _____
EMPLOYEE DATE OF BIRTH _____
EMPLOYER _____ # YRS. _____
NAME OF INSURANCE CO. _____
ADDRESS _____
TELEPHONE: _____
PROGRAM OR POLICY # _____
UNION LOCAL OR GROUP _____
SOCIAL SECURITY NO. _____

DENTAL INSURANCE 2ND COVERAGE

EMPLOYEE NAME _____
EMPLOYEE DATE OF BIRTH _____
EMPLOYER _____ # YRS. _____
NAME OF INSURANCE CO. _____
ADDRESS _____
TELEPHONE: _____
PROGRAM OR POLICY # _____
UNION LOCAL OR GROUP _____
SOCIAL SECURITY NO. _____

RELEASE

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.
I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.
I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE _____

DATE _____