

### Dental Insurance Information

Date: \_\_\_\_\_

#### Primary Dental Insurance Company

Insurance Company Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Subscriber ID#: \_\_\_\_\_ Phone #: \_\_\_\_\_

Family Members covered under the plan: \_\_\_\_\_

Local or Group Number: \_\_\_\_\_

**Assignment of Benefits**

I authorize payment of benefits to Dr. Ameri for dental services provided.

**Release of Information**

I authorize the release of any dental information necessary to process claims.

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Signature Date

#### Secondary Dental Insurance Company

Insurance Company Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Subscriber ID#: \_\_\_\_\_ Phone #: \_\_\_\_\_

Family Members covered under the plan: \_\_\_\_\_

Local or Group Number: \_\_\_\_\_

**Assignment of Benefits**

I authorize payment of benefits to Dr. Ameri for dental services provided.

**Release of Information**

I authorize the release of any dental information necessary to process claims.

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Signature Date