Patient Name: _____ **Date of birth:** _____

PRIMARY DENTAL INSURANCE

Subscriber Name: _____ Relation to patient: _____

Employer: _____ Ins Co: _____

Policy #: _____ Group #: _____

SS #: _____ DOB: _____

SECONDARY DENTAL INSURANCE

Subscriber Name: _____ Relation to patient: _____

Employer: _____ Ins Co: _____

Policy #: _____ Group #: _____

SS #: _____ DOB: _____

□ **please check if you do not have a dental insurance policy.**

I authorize my insurance company to pay Pediatric Dentistry PLC for all insurance benefits otherwise payable to me for services rendered. I also authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges for services rendered; whether or not it is covered by insurance, all broken appointment fees and all late payment service charges. I also understand that obtaining insurance coverage and benefit information is my responsibility and not the responsibility of Pediatric Dentistry PLC. This consent is to remain in effect from the date indicated until cancelled in writing.

_____ _____ _____

Authorized Signature **Relation to child** **Date**