DENTAL INSURANCE

Primary Company_____ Group #_____

Insurance address_____

Insurance phone #_____

Subscriber_____ Relationship to patient_____

Social Security Number_____ Date of Birth_____

Subscriber's Employer_____

Employer's Address (City, State, and Phone #)_____

Secondary Ins. Name_____ Group#_____

Insurance address_____

Insurance Phone#_____

Subscriber_____ Relationship to patient_____

Social Security Number_____ Date of Birth_____

Subscriber's Employer_____

Employer's Address (City, State and Phone #)_____

MEDICAL INSURANCE

Primary Company_____ Group #_____

Insurance Phone #_____ Subscriber_____

Address of insurance (City, State, Phone #)_____

Relationship to patient_____ Social Security Number _____

Date of Birth_____

Your signature is necessary for us to process all insurance claims, to ensure payment for services rendered, and to release medical information to other providers, when necessary, for treatment.

I authorize the release of certain protected health information (PHI) about me when necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical\dental care. I assign all medical and surgical benefits, including major medical benefits to which I am entitled, to Dr. Thomas B. Braun. This assignment will remain in effect until revoked by me in writing or expire on date of completed treatment. A photocopy of this assignment is to be considered as valid as the original.

By signing this form you hereby accept responsibility to pay your estimated insurance co-payment at the time of service.

X Signature of Patient_____ **Date**_____

Parent or legal guardian