DENTAL INSURANCE INFORMATION

Patient name_____SS#_____ DOB_____

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Primary Dental Insurance_____Contact #(____)_____

Dental Ins Address_____City_____State_____ZIP_____

Policy Holder Name_____Employer_____ Group #_____

Subscriber ID #_____DOB_____

Secondary Dental Insurance_____Contact(___) _____

Dental Ins Address_____City_____State_____ZIP_____

Policy Holder Name_____Employer_____Group #_____

Subscriber ID #_____DOB_____

I hereby authorize and give consent to Irina Adler, DDS, MS to submit to my insurance for my dental treatment. I understand that my insurance is not a guarantee of payment. I understand if they do not pay on my dental claim I am fully responsible for the full fee. I understand that the balance owed needs to be paid in thirty days. I hereby authorize and direct payment of the dental benefits directly to Dr. Irina Adler.

Signature of patient or guardian_____Date_____