PLEASE PROVIDE US WITH THE FOLLOWING DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
Employee Name ____________________	Employee Name ______________________________
Birth Date _________________________	Birth Date ___________________________________
SS# or ID# ________________________	SS# or ID# ___________________________________
Employer ___________________________	Employer ____________________________________
Dental Ins. Co. ______________________	Dental Ins. Co. _______________________________

I hereby authorize my insurance benefits to be paid directly to San Jose Endodontics. I am financially responsible for services not covered or paid for by my insurance company for any reason. I also authorize this office to release any information required about my dental condition/treatment needed to determine benefits for as long as it takes to have the claim settled.

Signature ____ Date _______________________
(Patient, Parent or Guardian)