

# DENTAL INSURANCE AUTHORIZATION FORM

## PATIENT INFORMATION

|                               |               |  |                    |  |
|-------------------------------|---------------|--|--------------------|--|
| Patient Name<br>First MI Last |               |  | Sex<br>Male Female |  |
| Patient's Birthdate           | Patient's SS# | If patient is a full time student, name of school: |                    |  |

## PRIMARY DENTAL INSURANCE INFORMATION

|                                     |  |         |  |                           |
|-------------------------------------|--|---------|--|---------------------------|
| Employee's Name<br>First MI Last    |  |         | Employee's SS#   | Employer's Name & Address |
|                                     |  |         | Employee's Birthdate   |                           |
| Name & Address of Insurance Company |  | Group # | Relationship to Patient<br><input type="checkbox"/> Self <input type="checkbox"/> Spouse<br><input type="checkbox"/> Parent <input type="checkbox"/> Other |                           |

## SECONDARY DENTAL INSURANCE INFORMATION

Is the patient covered by a secondary dental insurance plan?  Yes  No If Yes, complete the following:

|   |  |         |  |                           |
|---|--|---------|--|---------------------------|
| Employee's Name<br>First MI Last              |  |         | Employee's SS#   | Employer's Name & Address |
|   |  |         | Employee's Birthdate   |                           |
| Name & Address of Secondary Insurance Company |  | Group # | Relationship to Patient<br><input type="checkbox"/> Self <input type="checkbox"/> Spouse<br><input type="checkbox"/> Parent <input type="checkbox"/> Other |                           |

I agree to be responsible for all charges for dental services not paid by my dental plan, unless the treating dentist or dental practice has a contractual agreement with my plan to write off a portion of the charges. I authorize the disclosure of my protected health information for treatment, payment and healthcare operations and the electronic, paper, fax or verbal transmission of protected health information to a clearinghouse, as well as, to and from my insurance company(ies), its employees and authorized representatives. I authorize the disclosure of my protected health information to my employer and my employer's personnel office for the purpose of processing my insurance claims or verification of coverage relating to my dental treatment and collecting unpaid balances for services rendered.

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

I hereby authorize payment of the dental benefits otherwise payable to me directly to the dentist named herein.

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

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