COLORADO KIDS PEDIATRIC DENTISTRY

INSURANCE INFORMATION

Primary Insurance Information

Name of Insured: _____

Relationship to Patient: _____

Insured Soc. Sec.: _____

Insured Birth Date: _____

Employer: _____

Ins. Company: _____

Address: _____

City, State, Zip: _____

Subscriber ID#: _____ Group#: _____

Secondary Insurance Information

Name of Insured: _____

Relationship to Patient: _____

Insured Soc. Sec.: _____

Insured Birth Date: _____

Employer: _____

Ins. Company: _____

Address: _____

City, State, Zip: _____

Subscriber ID#: _____ Group#: _____

I agree to be responsible for all charges for dental services and materials not paid for by my dental plan. I authorize release of any information as it relates to the processing of claims.

I assign insurance benefits for services rendered to *Colorado Kids Pediatric Dentistry*, and authorize *Colorado Kids Pediatric Dentistry* to maintain this signature on file to be used on my insurance claim submissions, whether manual or electronically filed.

_____ _____

Signature of Primary Insurance Subscriber Date

_____ _____

Signature of Primary Insurance Subscriber Date