East Main Dental Center, LLP

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SUBSCRIBER • INSURANCE INFORMATION

INSURANCE COMPANY	GROUP OR POLICY NUMBER	EFF. DATE	INSURANCE PHONE NO.
INSURANCE ADDRESS	CITY STATE ZIP		SOCIAL SECURITY NO.
EMPLOYER - NAME			DATE OF BIRTH

EMPLOYEE - NAME AND ADDRESS

COVERED MEMBERS

I HEREBY AUTHORIZE RELEASE OF INFORMATION RELATED TO CLAIMS, AND PAYMENT DIRECTLY TO THE ABOVE NAMED DENTIST OF THE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME, NOT TO EXCEED THE CHARGES SHOWN. I AUTHORIZE EAST MAIN DENTAL CENTER, LLP TO CONTACT MY EMPLOYER OR INSURANCE AGENT TO OBTAIN THE NECESSARY INFORMATION TO PROCESS THE ABOVE MENTIONED CLAIMS AND PAYMENTS.

DATE

SIGNATURE