## Dental Insurance

**Name of Dental Insurance Company _____**

**Your insurance is a contract between you and your insurance company. If, for any reason, your insurance fails to pay, YOU are responsible for FULL payment.**

**I authorize release of any information necessary to process my dental insurance claims. I understand that I am responsible for all costs of dental treatment.**

**Signed_____ Date_____**

**(Patient or Parent of Minor)**

**I hereby authorize payment directly to Dr. Dan Harrell of the group insurance benefits otherwise payable to me.**

**Signed_____ Date_____**

**(Insured Person)**

**If the insurance is drawn on your spouse or parent/guardian, please list the following information:

Insured full name:_____

Date of Birth:_____

SS#:_____