

Patient's Name _____ Birthdate _____

Patient's ID# _____

Insured's Name _____ Birthdate _____

Insured's S.S.# _____

1. Employed at _____

2. Insurance Carrier _____

3. Group# _____ Telephone# _____

X. _____
Signed (patient or parent if minor) _____ date

Den-Care Smile Center
G.R.Kozina, D.D.S & Associates , Ltd.

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847-DEN-TIST

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**DENTAL INSURANCE CLAIM RELEASE
AND AUTHORIZATION**