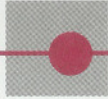


Stephen E. Kineret, DDS, MS



Orthodontic Specialist

Where patient care comes first

INSURANCE INFORMATION

PATIENT(S) NAME

The following authorizations shall remain valid and effective from the date of signing until revoked in writing.

AUTHORIZATION TO RELEASE INFORMATION—I hereby authorize any Provider, Insurer, or other Organization to release any information regarding the dental history, treatment, or benefits payable for the attached claim to the Plan Administrator or its authorized agent for the purpose of determining benefits payable.

AUTHORIZATION TO PAY BENEFITS TO DENTIST—I hereby authorize payment directly to STEPHEN E. KINERET, D.D.S.,M.S., of the Dental Benefits otherwise payable to me. I understand that I am financially responsible for any charges incurred not covered by my insurance carrier. **CERTIFICATION**-I certify that all information that I have supplied is true and correct.

Signature (Parent or Guardian)

Date

PRIMARY INSURANCE

SECONDARY INSURANCE

Insurance _____

Insurance _____

Group Number _____

Group Number _____

Insured _____

Insured _____

Parent Name _____

Parent Name _____

Date of Birth _____

Date of Birth _____

Social _____

Social _____

Security # _____

Security # _____

Employed By _____

Employed By _____

Business Phone _____

Business Phone _____

Business Address _____

Business Address _____

City, State, ZIP _____

City, State, ZIP _____

INSURANCE COMPANY ADDRESS

INSURANCE COMPANY ADDRESS

Name _____

Name _____

Address _____

Address _____

City _____

City _____

State _____ ZIP _____

State _____ ZIP _____

Phone _____

Phone _____

Amount of orthodontic coverage _____

Amount of orthodontic coverage _____

Primary _____

Secondary _____

IS THIS PLAN A PPO? _____

916-772-5832

Blue Oaks Marketplace

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