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

Insurance _____
Group Number _____
Insured
Parent Name _____
Date of Birth _____
Social
Security # _____
Employed By _____
Business Phone _____
Business Address _____
City, State, ZIP _____

SECONDARY INSURANCE

Insurance _____
Group Number _____
Insured
Parent Name _____
Date of Birth _____
Social
Security # _____
Employed By _____
Business Phone _____
Business Address _____
City, State, ZIP _____

INSURANCE COMPANY ADDRESS

Name _____
Address _____
City _____
State _____ ZIP _____
Phone _____
Amount of orthodontic coverage
Primary _____

INSURANCE COMPANY ADDRESS

Name _____
Address _____
City _____
State _____ ZIP _____
Phone _____
Amount of orthodontic coverage
Secondary _____

IS THIS PLAN A PPO? _____

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