INSURANCE INFORMATION

Primary Insurance

Employee's Name: _____
Employee's Birth Date: ___-___-_____
Employee's Social Security #: _____-____-_____
Employer's Name and Address: _____
_____
Insurance Carrier: _____
Group and/or Policy _____
Address to mail claims: _____
_____
****

Secondary Insurance

Employee's Name: _____
Employee's Birth Date: ___-___-_____
Employee's Social Security #: _____-____-_____
Employer's Name and Address: _____
_____
Insurance Carrier: _____
Group and/or Policy # _____
Address to mail claims: _____
_____

AUTHORIZATION TO RELEASE INFORMATION & HIPPA RELEASE

I authorize Richard S. Baum, D.M.D. to provide any insurance company, claim administrator, and consulting healthcare professional's information concerning health care, advice, treatment, or supplies provided. This information will be used exclusively for the purpose of evaluating and administering claims for dental benefits, and dental treatment.
I have also received a copy of Dr. Baum's Notice of Privacy Practices.

Patient or Authorized Guardian's Signature / Date