

## DENTAL INSURANCE

Subscriber: \_\_\_\_\_

Birth date \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Employer \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's name \_\_\_\_\_

Birth date \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Employer \_\_\_\_\_

Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(s) have insurance coverage with  
\_\_\_\_\_ and assign directly to  
\_\_\_\_\_ Insurance Company

Dr. Karim Malek all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submission.

The above named dentist may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent or Guardian

\_\_\_\_\_  
Please print name of Patient, Parent or Guardian

\_\_\_\_\_  
Date

I have had the opportunity to review the  
"Consent and Notice of Privacy and  
Practices" form.  
Signature \_\_\_\_\_