Childrens & Adolescent Dentistry, Ltd.

DENTAL INSURANCE CLAIM RELEASE AND AUTHORIZATION

Dr. Scott Shore Dr. Leo D. Morton

Corporate Federal Identification Number 36-276-2093

Patient Name ____________________

Employee Name ____________________

Employee Date of Birth ____________________

Employee ID. # __________ **Group#** __________

Employer Name ____________________

Employer Address (city only) ____________________

Insurance Carrier ____________________

Carrier Address ____________________

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I hereby authorize payment directly to the named Dental Corporation from my insurance carrier for professional services on the attached claim. I understand that I am responsible for any charges not covered by my dental insurance. I have reviewed the plan of treatment and further authorize the above named Dental Corporation to release any information relating to this claim.

X ____________________ **Date** __________

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