Lakeshore **W**est **D**ental
3390 Lake Shore Blvd., W. Office: 416-251-5707
Etobicoke, Ontario, M8W 1M9 www.lakeshorewestdental.com

CDAnet INSURANCE DATA INFORMATION CONSENT FORM

POLICY HOLDER INSURANCE INFORMATION

NAME OF POLICY HOLDER _____

DATE OF BIRTH _____

INSURANCE CO. _____

SUBSCRIBER ID NO. _____

PLACE EMPLOYMENT_____

Are you claiming from more than one insurance co. no_____ yes_____

OTHER POLICY HOLDER INSURANCE INFORMATION

NAME OF POLICY HOLDER _____

DATE OF BIRTH _____

INSURANCE CO. _____

SUBSCRIBER ID NO. _____

PLACE OF EMPLOYMENT _____

Other than the policy holder(s) above, indicate patient's name and relationship to insurance policy holder by encircling one of the following:

PATIENTS NAME_____ RELATIONSHIP * D S

PATIENTS NAME_____ RELATIONSHIP * D S

PATIENTS NAME_____ RELATIONSHIP * D S

*D=DEPENDANT S=SPOUSE

CONSENT FOR RELEASE FORM

I authorize release, to my insuring company plan administrator, the information contained in claims submitted electronically.

_____

Signature of patient or parent/guardian

CONSENT FOR ASSIGNMENT OF BENEFITS

I hereby assign my benefits payable from claims submitted electronically to Dr. Patel and to authorize payment directly to him.

_____

Signature of subscriber