# Lakeshore West Dental

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## *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

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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