CARPINELLO ORTHODONTICS
INSURANCE AUTHORIZATION

Insurance Company Name: ____

Employer Name: ____

Subscriber/Policyholder's Name: ____

Subscriber/Policyholder's DOB: ____

Subscriber/Policyholder's SS# or ID#: _______________________________________

Patient Name(s): ____

Relationship to Patient: ____

Authorization:

Subscriber/Policyholder's Authorization for payment of benefits.

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Carpinello Orthodontics.

____ ___________________

Signature of Policyholder Date