Daniel Shalev, D.D.S.
2510 Wigwam Pkwy #200
Henderson, NV 89074

Primary DENTAL Insurance:

Name of Insurance Co. _____

Name of Primary Insured _____

Date of Birth of Insured _____ ID #_____

Social Security Number _____ Group #_____

Relationship of Insured to Patient _____

Employer _____

Secondary DENTAL Insurance:

Name of Insurance Co. _____

Name of Primary Insured _____

Date of Birth of Insured _____ ID #_____

Social Security Number _____ Group #_____

Relationship of Insured to Patient _____

Employer _____

I hereby authorize my health care provider to affix my name to all insurance submission documents, and/or information requested by my insurance company(s) relating to any and all health benefits due to my dependants and myself.

I also authorize payment of healthcare benefits otherwise payable to me, directly to my dentist as listed above. **I agree to be held responsible for all charges and services not paid by my insurance company.**

_____ _____

Today's Date Signature of patient or insured

The signature on file (SOF) is valid from this date and expires in one year. A photocopy of this authorization may act as an original.