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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.**