RECORDS RELEASE AUTHORIZATION

TO_____

Doctor or Office

_____

Address

I hereby authorize and request you to release my dental records/information concerning my treatment while under your care to:

Dr. John Alan Smith

444 Clinchfield St Suite 303

Kingsport, TN 37660

(423) 247-7821
(423) 247-2156 fax

frontdesk@jasmithdds.com

PRINT NAME_____

ADDRESS_____

_____

SIGNATURE_____

Insurance Information we must have to get your benefits and send your claims

Name of Insurance Company

Primary : _____

Secondary: _____

Insurance Claims Address

Primary : _____

Secondary : _____

Insurance Phone Number for Providers

Primary : _____

Secondary : _____

Member ID #

Primary : _____

Secondary : _____

Group #

Primary : _____

Secondary : _____

Are YOU the Insurance Policy Subscriber holder?

Yes : ____ (Date of Birth ___/___/___ and Social Security # _____-_____-_____)

No : ____ (if NO fill out Subscriber information below)

Subscriber Name: _____

Social Security # : _____-_____-_____

Date of Birth: _____/_____/_____