PATERNINA DENTAL CENTER
37 E JERICHO TURNPIKE
MINEOLA, NY 11501-3104

SIGNATURE ON FILE

Subscriber Name (Please Print)_____

Birthdate_____ Social Security No: ____ ____ ____—____ ____—____ ____ ____ ____

☐I authorize use of this form on all my insurance submissions.
☐I authorize release of information to all my **Insurance Companies**.
☐I understand that **I am responsible** for my bill.
☐I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Company
☐I authorize payment directly to my doctor.
☐I permit a copy of this authorization to be used in place of the original.
☐My signature also applies to dependents listed on this form

_____

Subscriber Signature **Date**

DEPENDENT'S NAME	BIRTHDATE	COLLEGE