Robert A. Kiel, D.M.D., LLC

281 Hartford Turnpike
Vernon, CT 06066

Patient Name _____

Responsible Party Name _____ Home Phone _____

Address _____ Work Phone _____

City _____ State _____ Zip _____

Relationship to patient _____

PRIMARY

Dental Insurance Company _____

Insurance Company Address _____
Street City State Zip

Subscriber's Name _____

Subscriber's ID # _____

Subscriber's Soc. Sec. No. _____ Date of birth _____

Group Number _____

Employer's Name _____

SECONDARY

Dental Insurance Company _____

Insurance Company Address _____
Street City State Zip

Subscriber's Name _____

Subscriber's ID# _____

Subscriber's Soc. Sec. No. _____ Date of birth _____

Group Number _____

Employer's Name _____

I agree to pay Robert A. Kiel, DMD, LLC for any reasonable charges. I authorize the release of any medical information by Robert A. Kiel, DMD, LLC as necessary to process my claim. The authorization may be conveyed by a signed copy or photocopy of this form. .I hereby authorize payment of dental benefits otherwise payable to me directly to Robert A. Kiel, DMD, LLC. In the event that I fail to pay charges when due, and Robert A. Kiel, DMD, LLC refers collection of the amount to an attorney for collection, I agree to pay the interest and costs of collection including a reasonable attorney's fee.

_____ _____
Signature Date