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Insurance Information

Insured's Name: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ Patient's Date of Birth: _____

Insured's Place of Employment: _____

Insured's ID# _____ Group# _____

Name and Address of Insurance Company: _____

Insurance Company's Phone Number: _____

I have received the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or portion of such charges. To the extent permitted by law, I authorize release of any information relating to claims filed.

Signature of Insured Date _____

I hereby authorize payment of the dental benefits otherwise payable to me directly to Dr. Michael L. Danze, DMD.

Signature of Insured Date _____