SIGNATURE ON FILE AUTHORIZATION FORM

Employee (Subscriber) Name & Address

_____
_____
_____

Social Security #:_____

Date of Birth:_____

Employer Name & Address

_____
_____
_____

Primary Insurance

_____
_____

Group Name:_____Phone:_____

Secondary Insurance: YES / NO

**If YES, please submit an additional form for the insured. Thank You.

I authorize the release of any information relating to any claims made on myself or my dependents. I understand that I am responsible for all cost of dental treatment not covered by my insurance carrier. I hereby authorize payment directly to Richard D. Thayer D.D.S. of the group insurance benefits otherwise payable to me.

Insured:_____ Date: _____

Dr. Richard D. Thayer
Hanover Square, 435 New Karner Road, Albany, NY 12205
Phone: 518.456.1622