DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to patient_____

Insurance company_____

Group #_____

Is patient covered by additional insurance? Yes____ No_____

Subscriber's Name_____

Birth Date_____ SS#_____

Relationship to patient_____

Insurance company_____

Group#_____

Assignment and Release

I certify that, I and/or my dependent(s) have insurance coverage with

_____ (insurance company name)

and assign directly to Dr._____ all insurance benefit, if any, otherwise payable to me for service rendered. I understand that I'm financially responsible for all charges whether or not paid by insurance company. I authorize the use of my name on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to above-named insurance company(ies) and their agents to obtain payment for services and determine insurance benefits or benefits payable to related services.

_____

Signature of patient, patient's guardian or personnel representative

_____

Please print name of patient, patient's guardian or personnel representative

_____ _____

Relationship to patient Date