Assignment of Benefits Authorization Form for Dental Insurance

Patient Information

Patient Name

Date of Birth

MM/DD/YYYY

Address

Phone Number

Insurance Information

Insurance Company

Policy Number

Group Number (if applicable)

Assignment of Benefits Authorization

I authorize payment of dental benefits to the dental office for services rendered. I hereby assign all dental and/or medical benefits, to which I am entitled, to the above-named dental practice. I understand that I am financially responsible for any charges not covered by my insurance plan. I authorize the

Patient Signature

Sign here

Date

MM/DD/YYYY