Dental Benefits Payment Authorization and Release Form

Patient Information

Full Name

Date of Birth

Phone Number

Address

Insurance Information

Insurance Company

Policy Number

Group Number

Subscriber Name

Subscriber Date of Birth

Relationship to Patient

Assignment of Benefits and Release of Information

Please read carefully and sign below:

I authorize payment of dental benefits to the provider for services rendered. I understand that I am financially responsible for charges not covered by my insurance plan.

Patient or Guardian Signature

Date