Dental Provider Benefits Collection Assignment

Patient Information

Name: _____

Date of Birth: _____

Phone Number: _____

Dental Provider Information

Provider Name: _____

Practice/Clinic Name: _____

Contact Number: _____

Assignment of Benefits

I hereby authorize and assign all dental benefits directly to the above named dental provider for services rendered by them or their associates. I understand that I am financially responsible for all charges not covered by my dental insurance. I authorize the release of any information necessary to process this claim. This assignment will remain in effect until revoked by me in writing.

Patient/Guardian Signature

Date