Insurance Reimbursement Assignment Form Dental Treatments

Patient Information

Full Name

Date of Birth

Gender

Address

Phone Number

Insurance Information

Insurance Company

Policy Number

Group Number

Subscriber Name

Subscriber DOB

Relationship to Patient

Dental Treatment Details

Treatment Description

Date of Treatment

Provider/Dentist Name

Treatment Amount

Assignment of Benefits & Authorization

I hereby authorize payment of insurance benefits otherwise payable to me directly to the dental provider indicated above for services rendered. I authorize the release of any information relating to this claim.

Patient/Guardian Signature

Date

This form is for sample purposes only.