Patient Authorization for Dental Benefits Assignment

I authorize the release of any dental or medical information necessary to process my claims and request payment of dental insurance benefits either to myself or to the named provider below.

I assign the dental benefits otherwise payable to me directly to the provider listed below.

I understand that I am financially responsible for all charges not covered by my insurance, including deductible and co-payment amounts.

Patient Name: _____

Date of Birth: _____

Insurance Company: _____

Provider/Clinic Name: _____

_____

Patient/Guardian Signature

_____ Date