ASSIGNMENT OF BENEFITS

AUTHORIZATION AND RELEASE

I authorize and request my insurance company to pay directly to the dentist
or dental group insurance benefits otherwise payable to me. I authorize the
doctor to release all information necessary to secure the payment of benefits.
I am financially responsible for all charges whether or not paid by insurance.
I authorize the use of this signature on all insurance submissions, and credit
card payments.

Signature of patient or parent if minor	Date