Welcome To Our Office

Date _____

INSURED NAME	**INSURED DATE OF BIRTH**
INSURED EMPLOYER NAME	**INSURED GROUP ID #**
EMPLOYER STREET ADDRESS	**DENTAL BENEFIT COMPANY NAME**
EMPLOYER CITY ST ZIP	**MEDICAL INSURANCE CARRIER NAME**
I AUTHORIZE MY INSURANCE COMPANY TO PAY THE DENTIST ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS. I AUTHORIZE THE DENTIST TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS.	**I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES WHETHER OR NOT PAID BY INSURANCE.**

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Signature