FAMILY DENTAL CARE

SIGNATURE ON FILE

PATIENT'S NAME _____

Specialist Care

Family Dental Care is authorized to provide information concerning health care, advice, treatment, or supplies provided in the event I am referred to a Specialist for further treatment.

Signature _____ Date _____

Assignment of Benefits

I hereby authorize payment directly to Family Dental (Steven F. Biagini, D.D.S., Theresa M. Jansky, D.D.S., Mark D. Beck, D.D.S) of the dental benefits otherwise payable to me.

Signature _____ Date _____
Insured Person

Release of Information to Insurance Carrier

Family Dental Care is authorized to provide any insurance companies, claim administrators, and consulting health care professional information concerning health care, advice, treatment, or supplies provided. This information will be used for the purpose of evaluation and administrating claims for benefits.

I know I have the right to receive a copy of the authorization upon request and agree that the photographic copy of this authorization is valid as the original.

Signature _____ Date _____
Patient or Authorized Person

To our patients with Dental Insurance:

As your dental care provider we will make every effort to maximize your dental insurance. With our knowledge and experience of dental insurance we will do our best to give an accurate estimate of insurance benefits before any treatment is performed. However, due to insurance company benefit exclusions and alternate treatment provisions, our estimates are never a guarantee of benefits. Therefore any remaining balance on your account after an insurance claim is paid will be the responsibility of the patient.

Signature_____Date:_____