

BENNINGTON DENTAL CENTER

Family and Cosmetic Dentistry

YOUR SIGNATURE IS NECESSARY FOR US TO:

- PROCESS ALL INSURANCE CLAIMS
- ENSURE PAYMENT FOR SERVICES PROVIDED
- RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES NEEDED FOR THE PROCESSING OF YOUR CLAIMS
- RELEASE INFORMATION TO OTHER MEDICAL AND DENTAL PROVIDERS, INCLUDING LABORATORIES, WHEN NECESSARY, FOR YOUR TREATMENT

I hereby authorize the release of all medical information necessary to process my claims and I authorize release of this same information, when necessary, to other providers rendering medical/dental care, as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

I assign all medical and surgical benefits, including major medical benefits to which I am entitled, to Bennington Dental Center and/or Dr. Tyler Carmack and/or Dr. Elizabeth Carmack. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient Signature _____

Patient Full Name (printed) _____

Parent Signature (if minor) _____

Witness _____

Date Signed _____