PATIENTS NAME _____

Last First Initial

I hereby authorize payment directly to _____
(DENTIST'S NAME)

of the dental benefits otherwise payable to me.

_____
SIGNATURE (INSURED PERSON)

_____
DATE

Signature is valid for two years from the above date, unless revoked by me at an earlier date.

_____

_____

_____
ATTENDING D.D.S. NAME

is authorized to provide any insurance company(s), claim administrator(s) and consulting health care professionals, information concerning health care, advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits.

This authorization is valid for the term of coverage of the policy or contract, in force on this date only, or for two years, whichever is shorter.

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

_____
PATIENT OR AUTHORIZED PERSON'S SIGNATURE DATE

PATIENT NUMBER

104-1-94

SIGNATURE ON FILE