

AUTHORIZATION FOR SUBMISSION
OF CLAIMS AND
ASSIGNMENT OF BENEFITS

I authorize Dr. Kindem/Dr. Bennett to submit claims for payment of services to the insurance companies named below, on my behalf and in my name, and assign to Dr. Kindem/Dr. Bennett the group insurance benefits otherwise payable to me, but not to exceed the provider's charges for the covered services. I understand that I am financially responsible for any charges not covered by the group insurance benefits.

1. _____
(primary insurance company)

2. _____
(secondary insurance, if applicable)

(name of patient)

Date: _____

(signature of patient, parent or guardian)

AUTHORIZATION FOR RELEASE
OF HEALTH INFORMATION

I authorize Dr. Kindem/Dr. Bennett to release to the insurance companies or health care service plans, self-insurers, or their representatives, and all information and records (including x-rays) about my dental history, or about services rendered or treatment given to me, that is needed to review or evaluate any claim for benefits.

Date: _____

(name of patient)

(signature of patient, parent or guardian)