

PLEASE BRING YOUR INSURANCE CARD TO THE APPOINTMENT

Policy Holders Name: _____
Relationship to Patient: _____
Address: _____
City, State, Zip: _____
Social Security: _____
Insured's Birthday: _____
Policy Holders Employer: _____
Claim billing address: _____
City, State, Zip: _____
Telephone: _____
Policy/ Group Number: _____
ID Number: _____

ASSIGNMENT OF BENEFITS

UNDERSTAND THAT MY CONTRACT FOR DENTAL INSURANCE COVERAGE IS BETWEEN THE INSURANCE CARRIER AND ME. I AM ALSO AWARE THAT Dr. Robert D. Solomon, DDS WILL BILL MY INSURANCE CARRIER AS A COURTESY, AND THAT THE ULTIMATE RESPONSIBILITY FOR CHARGES ON MY ACCOUNT IS MINE. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE-NAMED DENTIST FOR THE GROUP DENTAL INSURANCE BENEFIT.

Signature of Insured

Date