

ASSIGNMENT OF INSURANCE BENEFITS
TO
DONALD J. ROTH, D.D.S.

If you have dental insurance your signature is required below in order for our office to bill and accept payment of any possible benefits you may have through your insurance plan. Thank you.

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN.
I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO
THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL
COSTS OF DENTAL TREATMENT.

Signed (Patient or parent if minor)

Date

I HEREBY AUTHORIZE PAYMENT OF THE DENTAL BENEFITS
OTHERWISE PAYABLE TO ME DIRECTLY TO THE ABOVE NAMED
DENTAL ENTITY.

Signed (Insured Person)

Date