

INSURANCE ASSIGNMENT AND RELEASE

L. Dawn Christian, D.D.S.

71 Valley Street, Suite 101

South Orange, NJ 07079

Telephone: (973) 761-4800

I certify that I, and/or my dependent(s), have insurance coverage

with _____ and assign directly
Name of Insurance Company(ies)

to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Guardian or Personal Representative

Date

Please print name of Patient, Guardian or Personal Representative

Relationship to Patient