To be completed if insurance benefits are to be assigned directly to the dentist:

I hereby authorize payment to Dermody Pediatric Dentistry & Orthodontics of all dental benefits due me, if any, by reason of services rendered, as provided in the policy. I understand that I am financially responsible for charges not covered by the policy or that are unpaid after 60 days.

Name of Insurance Company:_____

Insurance Company Mailing Address:_____

Insurance Company Phone #_____

Employer:_____

Group #:_____

Policy Holder's Name:_____

Policy Holder's I.D. #:_____

SS#_____ Date of Birth_____

Child's Name_____

SS#_____ Date of Birth_____

Child's Name:_____

SS#_____ Date of Birth:_____

Child's Name:_____

SS#_____ Date of Birth:_____

Please sign below, so that we may file your insurance.

_____ _____

(Policy Holder's Signature) **(Date)**