

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 _____
Insurance Company Name _____
Claim billing address _____
City, State, Zip _____
Telephone # _____
Policy/ Group Number _____
ID Number _____

ASSIGMENT OF BENEFITS

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

Signature of Insured

Date