Morristown
COSMETIC DENTISTRY

PATIENT DENTAL BENEFITS EXPLANATION

In consideration of the dental treatment to be rendered to me, my spouse or my dependents covered by my insurance policy;

I agree to sign over every dental benefit payment issued to me for dental services performed by the office if there is any balance outstanding.

□ I am aware that this office may file claims electronically and I hereby authorize my doctor and the staff to act as **my** agent in helping me obtain payment directly from my insurance companies.

□ I authorize release of any information relating to claims to **all my Insurance Companies.**

□ I fully understand that **I am responsible** for all charges for dental services not paid for by my dental benefit plan if a service is denied or I have already reached a maximum.

□ I authorize payment directly to Dr. Victor Gittleman of the group insurance benefits otherwise Payable to me.

□ I permit a copy of **my signature below** to be used in place of the original.

□ By signing below, I authorize the use of this form on **all** my insurance claim submissions and my signature also applies to dependents listed below.

Subscriber Name: _____

Subscriber Signature: _____ Date: _____

Family Members in my account	College Name if applicable	Birthdate of patient
1.		
2.		
3.		
4.		