FLEMING ISLAND FAMILY DENTISTRY, P.A.

Please Read and Initial Each Section Below:

___________ ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Fleming Island Family Dentistry, PA. of any and all dental benefits applicable and otherwise payable to me. I understand that I am financially responsible to Fleming Island Family Dentistry, PA. for charges not covered by this assignment.

____________RELEASE OF INFORMATION: I hereby authorize Fleming Island Family Dentistry, PA. to furnish my insurance company with any and all information that may be contained in my medical and dental records that relates to procedures performed at Fleming Island Family Dentistry, PA.

____________I understand that AS A COURTESY, Fleming Island Family Dentistry, PA. will submit a pre-treatment estimate to my dental insurance company if my treatment exceeds $300.00. THIS SERVICE IS AVAILABLE UPON MY REQUEST.

NAME ______________________________

DATE _____________________

Signature of responsible party

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