



AMAZING SMILES

### Assignment of Benefits Form

I hereby assign all dental benefits to which I am entitled to Amazing Smiles Dentistry. This applies for all insurance carriers and any other health/medical plan. This form will be kept on file. I understand that it is my responsibility to report any changes in insurance coverage.

I authorize the release of any medical or pertinent information necessary to obtain these benefits to my insurance carrier, or any other medical entity for continued dental care.

I understand that Amazing Smiles Dentistry is not in my network and that I am financially responsible for any amount not covered by insurance, and that payment of my portion is required at the time services are provided.

Patient Name (printed)\_\_\_\_\_

Signature\_\_\_\_\_Date\_\_\_\_\_

Witness\_\_\_\_\_