# RELEASE AND ASSIGNMENT

Dear Patient:

As a courtesy to our patients, our staff will prepare necessary dental insurance claim forms for all qualifying treatment performed by doctors or hygienists in this office. In order for us to process these forms efficiently through our computer and obtain a rapid response from the insurance company, we require this release and assignment form be completed and signed below.

If you do not wish to complete this form, you will be responsible for all claim submittals to your insurance company and this office will look to you for payment of all services rendered.

**Date:** _____

**Patient's Name:** _____

**1st Insured's Name:** _____
**Primary Insurance:** _____**Group#** _____
**Through Employer:** _____
**Birthdate:** _____

**2nd Insured's Name:** _____
**Secondary Insurance:** _____ **Group #** _____
**Through Employer** _____
**Birthdate:** _____

I hereby authorize the release of any information, including the diagnosis and the records of any treatment(s) or examination(s) rendered, to my insurance company (ies).

This release is solely for the purpose of facilitating the billing and reimbursement directly to the Doctor of insurance benefits to which I am entitled.

**Signed** _____

**Signed** _____

**Frank A. Riccoboni, D.D.S., M.S.**
**Eric R. Chu, D.D.S., M.S.**

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