BEBAR FAMILY DENTAL

INSURANCE ASSIGNMENT

AND

DENTAL RECORDS RELEASE

I hereby authorize any and all insurance benefit from whichever company I and my family are currently insured by or may become insured by, to be directly paid to **Bebar Family Dental**. I understand that I am financially responsible for the total charge and all non-covered services as it may be determined by my Insurance Company.

I authorize **Bebar Family Dental**. To release any information and/or dental records required to process any and all insurance claims filed on my behalf on any one of my family members.

INSURED'S NAME_____

INSURED'S ADDRESS: _____

_____

CITY STATE ZIP CODE

SIGNATURE: _____DATE: _____

2722 CATON FARM RD., JOLIET, IL. 60435 (815)782-6409 FAX: (815)867-6893