HAVEN FAMILY
DENTAL

INSURANCE ASSIGNMENT AND DENTAL RECORDS RELEASE

I hereby authorize any and all insurance benefits from whichever company I and my family are currently insured by, or may become insured by, to be directly paid to **Haven Family Dental**. I understand that I am financially responsible for the total charge and **all none covered** services as it may be determined by my Insurance Company.

I authorize **Haven 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/EMPLOYEE NAME: _____

INSURED'S/EMPLOYEE ADDRESS: _____

_____

CITY **STATE** **ZIP**

INSURED'S SIGNATURE: _____ **DATE:** _____