Insurance Information

Assignment of Release:

I hereby authorize payment directly to Renée L. I. Owen, DDS for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

PRIMARY DENTAL INSURANCE _____

Employer _____ _____

Policy Holder_____
(Last) (First) (Middle)

D.O.B._____ SS#_____ ID#_____ Group#_____

SECONDARY DENTAL INSURANCE _____

Employer _____ _____

Policy Holder_____
(Last) (First) (Middle)

D.O.B._____ SS#_____ ID#_____ Group#_____

** Signature:_____ Date:_____