AUTHORIZATION FOR SUBMISSION OF CLAIMS AND ASSIGNMENT OF BENEFITS

I authorize Northshore Dental to submit claims for payment of services to the insurance companies named below, on my behalf and in my name, and assign to Northshore Dental the group insurance benefits otherwise payable to me, but not to exceed the provider's charges for the covered services. I understand that I am financially responsible for any charges not covered by the group insurance benefits.

1. _____

2. _____

3. _____

DATE _____ _____
(name of patient)

_____
(signature of patient, parent, or guardian.)

-------- ----------

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize Northshore Dental to release to the insurance companies or health care service plans, self-insurers, or their representatives, any and all information and records (including x-rays) about my medical history, or about services rendered or treatment given to me, that is needed to review or evaluate any claim for benefits.

DATE _____ _____
(name of patient)

_____
(signature of patient, parent or guardian)