

Drs. Drumm & Catanzano, PC

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Comprehensive & Cosmetic Dentistry

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PATIENT AUTHORIZATION AND DENTAL BENEFITS INFORMATION

Employee Name _____

Employee Date of Birth _____

Employee SS# _____

Employer _____

Insurance Company _____

Address _____

Phone _____

Group # _____

I attest to the accuracy of the information of this page.

I understand that my payor for my dental benefits or dental care insurance carrier may pay less than the actual bill for services. I understand I am financially responsible for payments in full on all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

Patient's/(Guardian's) Signature _____ Date _____

PATIENT AUTHORIZATION: Release of Information/Financial Responsibility

For Signature on File

I _____ hereby authorize the office of Drs. Drumm & Catanzano, PC. to affix my name to any and all claims or documents as related to any and all health benefits due me.

I agree to be responsible for all charges for dental services and materials, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize the release of any information relating to this claim.

This "*Signature on File*" will be valid from this date.
A photocopy of this document may act as an original.

Patient's/(Guardian's) Signature _____ Today's Date _____
(for "*Signature on File*")