

John W. Drumm, D.M.D., P.L.L.C.
3301 New Mexico Avenue NW, Suite 230
Washington, DC 20016

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 John W. Drumm, D.M.D., P.L.L.C. 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*")