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YOUR SIGNATURE IS NECESSARY FOR US TO:

1. Process all insurance claims
2. To ensure payment for services rendered
3. To release medical information to insurance companies
4. To release and/or obtain information to/from other medical/dental providers, when necessary, for your treatment

I authorize the release of all medical information necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical/dental care. I assign all medical and surgical benefits, including major medial benefits to which I am entitled, to Matthew E. Sheldon, DMD, PA. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as original.

____ Patient Name (print)

____ Patient Signature

If minor:

____ Responsible Party (print)

____ Signature

____ Witness Name

____ Witness Signature

____ Today’s Date