Charles Khoury, D.M.D, Inc.

INSURANCE CONSENT FORM

Who is responsible for this account? _____ *Relationship to patient* _____

Subscribers Name _____ Birthdate __ _____

Subscribers Employer _____

Insurance Company _____ Group # _____

Subscriber ID _____ Relationship to patient: _____

Is patient covered by additional insurance? Yes No

Subscribers Name _____ Birthdate __ _____

Subscribers Employer _____

Insurance Company _____ Group # _____

Subscriber ID _____ Relationship to patient: _____

Assignment and Release

I certify that I, and/or my dependents(s), have insurance coverage with above insurance company And assign directly to Dr. Charles Khoury all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Charles Khoury may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____ _____

Signature of Patient or Guardian Date Relationship to patient