Mark R. Taylor, D.M.D.

To be completed if insurance benefits are to be assigned directly to the dentis

I authorize my insurance company to pay to Dr. Taylor all insurance benefits otherwise payable to me for services rendered. I authorize Dr. Taylor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I give Dr. Taylor permission to keep my signature on file to file my insurance for me.

Policy Holder's Signature: ______________________________ Date: ______

Patient Name: ______________________________

Insured's Name: ______________________________

Insured's Social Security Number: ______________________________

Patient's Social Security Number: ______________________________

Insurance Company: ______________________________

Telephone: ______________________________

Address: ______________________________

____

Group Name: ______________________________

Employer: ______________________________

Insurance Effective Date: ______________________________

INSURANCE INFORMATION