WENTWORTH
FAMILY DENTAL

Assignment of Dental Benefits (Direct Bill) Authorization Form

I_____ Authorization Wentworth Family Dental, to apply any outstanding balance on my account not covered by my insurance company or companies to the credit card listed below. I understand that the amount I pay at the time of my appointment is an estimate only based on details supplied by my dental plan and coverage.

Please list any dependants that will be using the credit card for Direct billing purposes.

_____

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I understand that Wentworth Family Dental will send a copy of the receipt and an Explanation of Benefit from my insurance company to my current address.

Name on Credit Card:_____

Credit Card #_____Expire Date:_____

Signature of Card holder:_____ Date:_____