You need only sign if we are billing dental insurance for you.

SIGNATURE ON FILE

POLICY HOLDER'S NAME_____

East Bay Family Dentistry
Dr. Jan Manning
862 Munson Ave.
Traverse City, MI 49686
231-946-4443

I authorize use of this form on all my insurance submissions.
I authorize release of information to all my Insurance Companies.
I understand that I am responsible for my bill.
I authorize the doctor to act as my agent in helping me obtain payment from my insurance companies.
I authorize payment to directly to my doctor.
I permit a copy of this authorization to be used in place of the original.
My signature also applies to the dependents listed below.

Authorized signature_____Date_____

Dependents Name	Birth Date	College (if over 18 yrs old)