INSURANCE ASSIGNMENT AND RELEASE

Sheepshead Bay Oral Surgery, PLLC
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I certify that I, and /or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Drs. Tokar/Zats 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.

The above-named physician 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 payable for related services.

_____ _____
Signature of Patient, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Guardian or Personal Representative Date