Penney Weeks DMD
Carla Field DDS
228 Ponte Vedra Park Dr. #100
Ponte Vedra Beach, FL 32082
(904)285-1990

Insurance Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Dr. Penney Weeks 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 dentist may use my health/dental 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. This consent will end when my current insurance coverage is terminated.

_____ _____
Signature of Patient or Guardian Date

_____ _____
Print name of patient or guardian relationship to patient

Changes to insurance:

_____ _____ _____
Insurance co Date Initial

_____ _____ _____
Insurance co Date Initial

_____ _____ _____
Insurance co Date Initial