Insurance Information	Patient Name:

Primary Coverage	**Secondary Coverage**
Relation to Subscriber: ___Self ___Spouse ___Child	Relation to Subscriber: ___Self ___Spouse ___Child
Subscriber:_____	Subscriber:_____
SS#: _____DOB:_____	SS#: _____DOB:_____
Employer:_____	Employer:_____
Insurance Name: _____	Insurance Name: _____
Phone #: _____	Phone #: _____
Group No: _____	Group No: _____

Assignment of Benefits

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to: BV Family & Cosmetic Dentistry (Dr. Amandeep B. Virk), 2 Union Square, Suite 230, Union City, CA 94587. If my current policy prohibits direct payment to doctor, I hereby instruct and direct you to make out the check to me and mail is as follows: C/O BV Family & Cosmetic Dentistry (Dr. Amandeep B. Virk), 2 Union Square, Suite 230, Union City, CA 94587 for the professional or dental expense benefit allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY

This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I also authorize the release of any information pertinent to my case to insurance company adjuster, or attorney involved in case.

Patient authorizes the Doctor to deposit checks received on Patient's account with made out to patient.

I authorize the Doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

A photo copy of this Assignment shall be considered as effective as the original.

Signature of Policy Holder or Claimant: _____ Date:_____

Signature of Witness: _____