A. CHRISTOPHER BERNARDINI D.D.S.

Signature On File

- I authorize A. CHRISTOPHER BERNARDINI DDS to use my name on any or all claims that relate to my health insurance benefits due to me or my dependents. If I do not have dental insurance, this does not pertain to me.

  ☐ I agree

- I authorize release of any information related to my insurance company or their related parties. If I do not have dental insurance, this does not pertain to me.

  ☐ I agree

- I authorize the office to act as my agent in helping me to obtain payment from my insurance company. If I do not have dental insurance, this does not pertain to me.

  ☐ I agree

- I authorize payment of health benefits directly to the office. If I do not have dental insurance, this does not pertain to me.

  ☐ I agree

- I understand that I am fully responsible for my bill and agree to pay all charges for services and items provided to me.

  ☐ I agree

- I permit a copy of this document to be used in place of the original.

  ☐ I agree

First Name ___________________ MI_______ Last Name _____________________

SIGNATURE _____________________________ Date ___________________________