Main Street Dental

We are on your side!

Assignment of Benefits

I understand that payment is due in full at time of treatment, unless prior arrangements have been approved.

I understand that I am responsible for payment of services rendered and am also responsible for paying any co-payment and deductibles that my insurance does not cover.

I hereby authorize payment directly to Main Street Dental of the group insurance benefits otherwise payable to me.

I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____ Today's Date _____ /_____ /_____

Patient or Responsible Party Signature

Your Main Street Dental team is here to help you.
Please let us know if you have ANY questions at all.