RONDA TROTMAN, D.M.D., L.L.C
www.tanasbournedentalcare.com

ASSIGNMENT AND RELEASE

I, _____ the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Ronda Trotman all insurance benefits, if any, otherwise payable to me for serviced rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ ____/____/____

Relationship Date

Tanasbourne Dental Care
2471 N.W. 185th Avenue
Hillsboro, OR 97124
(503) 690-9536
Fax (503) 690-0520