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38. MI: 39. LAST NAME: 40. HOME PHONE: 41. STREET ADDRESS: 42. CITY, STATE, ZIP CODE: 43. BIRTH DATE: 44. EMPLOYER: 45. EMPLOYER'S ADDRESS: 46. INSURANCE CO:: 47. CONTRACT NUM OR S.S. NUM: 48. PLAN NAME: 49. GROUP NUM: 50. PATIENT' RELATION WITH SUBSCRIBER: 51. ARE YOU ELIGIBLE FOR ADDITIONAL DENTAL INSURANCE PLAN NAME: 10. NO. YES, NAME OF THE SUBSCRIBER: 10. INSURANCE PLAN NAME: 10. CONTRACT NUM: 10. CONTRACT NUM: 10. ASSIGNMENT AND RELEASE (Does not apply to discount plans) I, the undersigned, certify that I (or my dependent) have insurance coverage with 11. and assign directly to Jorge Munoz, D.M.D., P.A. 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 the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance claims.	36: E-MAIL:						
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45. EMPLOYER'S ADDRESS: 46. INSURANCE CO: 47. CONTRACT NUM OR S.S. NUM: 48. PLAN NAME: 49. GROUP NUM: 50. PATIENT' RELATION WITH SUBSCRIBER: SELF SPOUSE CHILD OTHER 51. ARE YOU ELIGIBLE FOR ADDITIONAL DENTAL INSURANCE? NO YES, NAME OF THE SUBSCRIBER: INSURANCE: PLAN NAME: CONTRACT NUM: ASSIGNMENT AND RELEASE (Does not apply to discount plans) I, the undersigned, certify that I (or my dependent) have insurance coverage with and assign directly to Jorge Munoz, D.M.D., P.A. 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 the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance claims.	37. SUBSCRIBER'S FIRST NAME:					E PHONE:	
47. CONTRACT NUM OR S.S. NUM: 48. PLAN NAME: 49. GROUP NUM: 50. PATIENT' RELATION WITH SUBSCRIBER: 51. ARE YOU ELIGIBLE FOR ADDITIONAL DENTAL INSURANCE ?: NO YES, NAME OF THE SUBSCRIBER: INSURANCE: PLAN NAME: CONTRACT NUM: ASSIGNMENT AND RELEASE (Does not apply to discount plans) I, the undersigned, certify that I (or my dependent) have insurance coverage with and assign directly to Jorge Munoz, D.M.D., P.A. 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 the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance claims.	41. STREET ADDRESS:	42. CITY, STATE, ZIP CODE:			43. BIRTH	HDATE:	
50. PATIENT RELATION WITH SUBSCRIBER: SELF SPOUSE CHILD OTHER 51. ARE YOU ELIGIBLE FOR ADDITIONAL DENTAL INSURANCE? NO YES, NAME OF THE SUBSCRIBER: PLAN NAME: CONTRACT NUM: ASSIGNMENT AND RELEASE (Does not apply to discount plans) I, the undersigned, certify that I (or my dependent) have insurance coverage with and assign directly to Jorge Munoz, D.M.D., P.A. 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 the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance claims.	44. EMPLOYER:	45. EMPLOYER'S ADDRESS:			46. INSUF	RANCE CO.:	
YES, NAME OF THE SUBSCRIBER: OTHER INSURANCE: PLAN NAME: CONTRACT NUM: ASSIGNMENT AND RELEASE (Does not apply to discount plans) I, the undersigned, certify that I (or my dependent) have insurance coverage with and assign directly to Jorge Munoz, D.M.D., P.A. 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 the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance claims.	47. CONTRACT NUM. OR S.S. NUM.:	48. PLAN NAME:			49. GROU	JP NUM.:	
ASSIGNMENT AND RELEASE (Does not apply to discount plans) I, the undersigned, certify that I (or my dependent) have insurance coverage with and assign directly to Jorge Munoz, D.M.D., P.A. 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 the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance claims.	50. PATIENT' RELATION WITH SUBSCRIBER	5 5	1. ARE YOU ELIG	BLE FOR ADDITIONA	L DENTAL	Insurance ?: No	
ASSIGNMENT AND RELEASE (Does not apply to discount plans) I, the undersigned, certify that I (or my dependent) have insurance coverage with	SELF SPOUSE CHILD	YES, NAME OF THE SUBSCRIBER:					
ASSIGNMENT AND RELEASE (Does not apply to discount plans) I, the undersigned, certify that I (or my dependent) have insurance coverage with and assign directly to Jorge Munoz, D.M.D., P.A. 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 the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance claims.	OTHER						
I, the undersigned, certify that I (or my dependent) have insurance coverage with and assign directly to Jorge Munoz, D.M.D., P.A. 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 the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance claims.			PLAN NAME:	cc	ONTRACT N	IUM:	
and assign directly to Jorge Munoz, D.M.D., P.A. 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 the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance claims.	ASSIGNME	NT AND R	ELEASE (Doe	s not apply to disc	count plai	ns)	
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tion necessary to secure the payment of benefits. I authorize the use of my signature on all insurance claims.					me for serv	ices rendered. I understand	
						ctor to release all informa-	
RESPONSIBLE PARTY SIGNATURE RELATIONSHIP WITH PATIENT DATE	tion necessary to secure the payment of b	enents. I autho	onze tne use of my	signature on all insuranc	e ciaims.		
	RESPONSIBLE PARTY SIGNAT	'URE	REL	ATIONSHIP WITH P	ATIENT	DATE	