

**Elaine S. Martinez, DMD, PA
DENTISTRY 4 CHILDREN
904-215-4221 at Fleming Island
904-404-4444 at OakLeaf**

Assignment of Benefits

Please read and initial each section below:

_____ I hereby authorize payment directly to Elaine. S. Martinez, D.M.D., of any and all dental benefits applicable and otherwise payable to me. **I understand that I am financially responsible to Dr. Elaine S. Martinez for all charges not covered by this assignment.**

Release of Information

_____ I hereby authorize Dr. Elaine S. Martinez, to furnish my insurance company with any and all information that may be contained in my child's medical and dental records that relates to procedures performed in the office of Dr. Elaine Martinez.

_____ I understand that **AS A COURTESY**, Dr. Elaine S. Martinez will submit a pre-treatment estimate to my dental insurance company if my treatment exceeds \$600.00.

This service is available upon my request.

Signature of parent/ guardian

Date

Witness

Date