Redlands Dental Surgery Center

1180 Nevada St., Ste#100.
Redlands, CA 92374
(909)335-0474 or Fax (909)335-0477

Patient Name: ___________________________________ Date of Birth:__________________

Consent to bill insurance plan(s):

I give permission for Redlands Dental Surgery Center to bill my insurance company(ies) for covered services and to exchange information necessary to secure payment for these services. (Such necessary information may include patient name, diagnosis, service dates, types of services, and other pertinent information needed to process claims). I understand that I am responsible to pay any balances not covered by my insurance plan. I also understand that if an insurance payment is made directly to me for services rendered at Redlands Dental Surgery Center, I am responsible for immediately forwarding such payments to the provider who rendered the service. I will notify Redlands Dental Surgery Center of any changes to the above names patient's dental insurance, health insurance and/or Medi-Cal/Denti-Cal coverage including denial information.

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Signature/Relationship Date