San Francisco Dental Spa
255 King Street, Suite A
San Francisco, CA 94107
(415) 644-0644

SIGNATURE ON FILE

- I authorize use of this form on all my insurance submissions.
- I authorize release of information to all my insurance companies.
- I understand that I am responsible for my bill.
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
- I permit a copy of this authorization to be used in place of the original.

Name (please print): _____

Signature: _____
Date: _____