BALFOUR DENTAL
CENTER FOR COMPLETE DENTISTRY

100 Cortona Way, Suite 100
Brentwood, CA 94513

Ph: (925)634-9901
Fax: (925)634-1352

Insurance Waiver

I give my approval and consent to start my dental treatment. To the best of my knowledge, I am currently eligible for dental treatment through my insurance company. I have reviewed the treatment plan and fees and hereby assume complete financial responsibility for services rendered that are not paid for by my insurance company.

_____ _____
Signature of patient and/or Insured Date

Authorization for Signature on File

_____and/or _____
Patient/Guardian Signature Insured

Authorize Balfour Dental to affix my name to any and all claims or documents as they relate to treatment in this office. I hereby authorize payment of dental benefits otherwise payable to me, to be sent directly to Balfour Dental. I authorize release of any information relating to the dental claim. A photocopy of this document may act as an original.