Signature on File Form

- I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for my balance regardless of my insurance benefits.
- I authorize release of any information relating to my dental claims

X_____ _____
Signed (Patient OR parent if a minor) **Date**

- I assign dental benefit payments to be paid directly to William L. McCune, c/o Creekside Dental from my insurance company.

X_____ _____
Signed (Patient OR Insured Person) **Date**

- I give permission for my dentist and his/her clinical team to take any necessary x-rays, photos, or study models to enable complete diagnosis and treatment

X_____ _____
Signed (Patient OR parent if a minor) **Date**

Creekside Dental
1149 Weiland Rd.
Buffalo Grove, IL 60089
847-634-4773