Patient Name _____

(Please Print)

Randy G. Raetz, DDS PLLC
2273 South Clinton Avenue, Suite 1
Rochester, NY 14618

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 and any collection charges and/or reasonable Attorney's fees that the Doctor incurs if a bill is not paid when due.
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
- I authorize payment directly to the doctor.
- I permit a copy of this authorization to be used in place of original.
- My signature also applies to the dependents listed on the back of this card.

Signature _____ Date_____

DEPENDENT NAME	DOB	SOCIAL SECURITY #
1.		
2.		
3.		
4.		
5.		
6.		
7.		