JOHN McQUILLEN, D.D.S.
904 W. 5TH St.
Wamego, Kansas 66547
(785) 456-9393

INSURANCE AUTHORIZATION

I authorize and request my insurance company to pay directly to the dentist. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of myself or my dependents.

_____
Signature of Responsible Party

_____
Date

CREDIT CARD AUTHORIZATION
(Optional choice of payment)

I authorize the balance of my account to be charged to the following credit card after my insurance carrier has paid their portion:

Master Card # _____ Exp Date _____ Code _____

Visa # _____ Exp Date _____ Code _____

Discover # _____ Exp Date _____ Code _____

_____
Signature

_____
Date