

I, \_\_\_\_\_, affirm that the dental insurance information that I have given is my current dental coverage as of today, \_\_\_\_\_.

If for any reason the above statement is incorrect, I take on full financial responsibility for all the charges incurred for services rendered. I also agree to inform the office of any coverage changes in the future.

*Signature* \_\_\_\_\_ *Date* \_\_\_\_\_