



**YOUR SIGNATURE IS NECESSARY FOR US TO:**

- 1. PROCESS ALL INSURANCE CLAIMS;**
- 2. ENSURE PAYMENT FOR SERVICES PROVIDED**
- 3. RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES NEEDED FOR THE PROCESSING OF YOUR CLAIMS**
- 4. RELEASE INFORMATION TO OTHER MEDICAL AND DENTAL PROVIDERS, INCLUDING LABORATORIES, WHEN NECESSARY, FOR YOUR TREATMENT.**

I hereby authorize the release of all medical information necessary to process my claims and I authorize release of this same information, when necessary, to other providers rendering medical/dental care, as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

I assign all medical and surgical benefits, including major medical benefits to which I am entitled, to DOCTOR/PRACTICE NAME. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient Full Name (printed) \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_

Witness \_\_\_\_\_

Date Signed \_\_\_\_\_

---

**Edward J. Monroe, D.D.S.**

[www.foralifetimeofsmiles.net](http://www.foralifetimeofsmiles.net)

*2424 Chartres St  
LaSalle, IL 61301  
Phone (815)223-6013  
Fax (815)223-1128*

*334 Backbone Road E  
Princeton, IL 61356  
Phone (815)875-1183  
Fax (815)879-2603*



### Image Use Release Form

I hereby attest that I am the person indicated on the attached photograph. I freely grant Dr. Edward Monroe irrevocable permission to publish this image, in whole or in part and for a length of time determined by Dr. Edward Monroe for any publication purposes, or lecture without remuneration. I understand that the picture could be used in conjunction with other images.

I warrant that said picture is free of any abuse of copyright law. I will hold harmless the aforementioned Dr. Edward Monroe from any liability by virtue of any distortion or alteration unless it can be proven that such alterations and or distortions were done with malicious intent.

I have read and fully understand the contents of this release. I declare that I am over the age of 18 years, and am fully competent to sign this release on my own behalf.

*(please print)*

Patient Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_

---

**Edward J. Monroe, D.D.S.**

[www.foralifetimeofsmiles.net](http://www.foralifetimeofsmiles.net)

2424 Chartres St  
LaSalle, IL 61301  
Phone (815)223-6013  
Fax (815)223-1128

334 Backbone Road E  
Princeton, IL 61356  
Phone (815)875-1183  
Fax (815)879-2603