PORTER, MARTIN, SALMAN, PA
Oral & Maxillofacial Surgery

PATIENT NAME _____

Dear Patient, Parent or Guardian:

After your insurance(s) has paid, *there may be* money due back to you. Please indicate below who should receive this refund.

(PLEASE PRINT)

RECIPIENT'S NAME _____

RECIPIENT'S ADDRESS _____

_____

RECIPIENT'S RELATIONSHIP TO PATIENT _____

SIGNATURE _____

DATE _____