CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for the delivery of proper dental care

I authorize release of any information concerning my (or my child's) healthcare, for advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits.

I authorize the release of any information concerning my (or my child's) healthcare, for advice and treatment to another dentist, or another healthcare professional and their staff.

CONSENT OF FINANCIAL RESPONSIBILITY

I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me.

I understand that my dentist and staff will estimate insurance benefits as close as possible. I understand that I am responsible for payment of the account, and providing correct insurance information.

I understand that if insurance is not applicable when dental services are rendered, my full payment is due at time of service.

DO WE HAVE YOUR PERMISSION TO:

Leave a reminder regarding your appointment on your answering machine?. **YES/NO**

Speak with other members of your household regarding your appointment? **YES/NO**

If yes, whom?:_____ Relationship _____

Any additional person(s):_____ Relationship _____

Print Patient Name_____

Relationship to Patient_____

Signature_____ Date_____

Signature_____ Date_____

Signature_____ Date_____