CERTIFICATION

To the best of my knowledge, the information provided on this form is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child has a change in health.

MINOR/CHILD CONSENT

I am the parent, guardian, or personal representative of _____

Please Print Name of Minor/Child

And there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

INSURANCE ASSIGNMENT AND RELEASE

I certify that I and/or my dependent is covered by insurance with_____

Name of Insurance Company (ies)

And assign directly to Dr. _____ all insurance benefits if any, otherwise; payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance company. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my minor/child's health care information and may disclose such information to the insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for the related services. This consent will remain active unless otherwise submitted in writing.

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians, or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges. I also understand that my insurance is submitted as a courtesy to me and is ultimately my responsibility to follow up with to make sure the claims are processed in a timely manner otherwise I will take full responsibility for the services provided.

_____ _____

Signature of Patient, Parent/Guardian or Personal Representative Date

_____ _____

Print Name of Patient, Parent/Guardian or Personal Representative Relationship to Patient

Medical History Update

Has there been any change in the patient's health since the last dental appointment? [ ] Yes [ ] NO

For what conditions? _____

Is the patient taking any new medications? [ ] Yes [ ] NO

Has there been any insurance or address changes? [ ] Yes [ ] NO

Changes?_____

_____ _____

Date Patient/Guardian Signature

_____

Printed Patient/Guardian Name