General Release

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and received answers to any questions regarding my medical-dental history. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary, and I consent to the release of this information. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

X_____ _____

(signature) Patient Parent Guardian (print name of Guardian)

Insurance Claims

It is our pleasure to process your insurance claims. However, due to Privacy Laws we are unable to communicate openly with your insurance company. In effect, we are not responsible for your insurance coverage.

X _____

Appointment Policy

Due to the busy nature of our office, we require two business days' notice to cancel or change any appointments to avoid unnecessary charges.

X_____

I give your office permission to contact me through email and text. I realize that these methods may not be 100% secure.

X_____