

Certification

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

Minor Child Consent

I am the parent, guardian, or personal representative of _____
Please Print Name of Minor/Child

Insurance Assignment and Release

I certify that my dependant(s) is covered by insurance with _____
Name of Ins. Company(ies)

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

The above-named doctor may use my minor/child's health care information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

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 the patient or me. I understand that filling a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

Signature of Parent, Guardian or Personal Representative Date

Print name of Parent, Guardian or Personal Representative Date

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? _____

Date Patients Signature