

Authorizations

In case of emergency, contact:

Name _____ Relationship _____

Home _____

Work _____ Cell _____

Who may we thank for referring you to us?

Our office uses fluoride in some instances. Please initial your preference:

_____ I prefer to NOT receive fluoride treatments

_____ Yes, you may administer fluoride treatments as recommended by Dr. King

With whom may we discuss the following information?

Anyone

Me only

-OR- these people

listed:

at home/ work/ cell

Appointment Time, Date, Reason

(for confirming appointments)

Treatment

Account / Financial info

Which method would you prefer we use to confirm appointments?

_____ E-mail _____ Cell _____ Home _____ Work

_____ Other: _____

PLEASE REVIEW THE FOLLOWING AND SIGN ELECTRONICALLY AT THE FRONT DESK.

AUTHORIZATION FOR INSURANCE:

The undersigned patient, in requesting examination and/ or treatment, authorizes the release of all information (including x-rays) relating to that examination or treatment to health service plans and insurance companies. I hereby authorize payment directly to the dentist, the group insurance benefits otherwise payable to me, but not to extend the actual

charges for the covered services. I understand that I am financially responsible for any charges not covered by the group insurance benefits.

AUTHORIZATION FOR TREATMENT:

After having discussed treatment with the dentist, I grant authority to the dentist to perform procedures and treatments, including administration of medicine, local and general anesthetics, and extractions along with other surgical and dental procedures that may be necessary, to include any x-rays.

The undersigned patient also authorizes the release of such information to any peer review committee of state and local dental associations, which may request it.