

**CONSENT FOR TREATMENT AND INSURANCE INFORMATION**

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms or treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employ any such assistance as he/she deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me and my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

**Primary Insurance**

**Secondary Insurance**

Insured's Name \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Phone \_\_\_\_\_

Employer \_\_\_\_\_

Employer \_\_\_\_\_

Group# \_\_\_\_\_

Group# \_\_\_\_\_

**Insurance Agreement**

I certify that the above information is correct and in force. I am aware that it is my responsibility to read and understand my own dental insurance policy, including benefits, limitations and exclusions. I understand that the estimated portion that is due from me is estimated according to expected coverage, which may not be disclosed nor guaranteed, by my insurance company. I understand my portion may be more if my insurance company does not pay the anticipated amount. I also understand that services are rendered independent of insurance reimbursement.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date