Patient's Name: ____ Date of Birth:_________________________

Consent for Treatment

I, the undersigned, hereby consent to such treatment, procedures and patient care which, in the judgement of my dentist and dental hygienist may be considered necessary or advisable while a patient at Future of Dentistry.

Patient/Guardian Signature:____ Date: ____________________

Notice of Privacy Practices and Patient Bill of Rights

Future of Dentistry will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed Notice of Privacy Practices document to help you better understand our policies in regard to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facility and have copies available for distribution. The undersigned acknowledges that they have read the Notice of Privacy Practices and Patient Bill of Rights, and understands a physical copy is available upon request.

Patient/Guardian Signature:____ Date: ____________________

Consent of Release of Information & Assignment of Benefits & Financial Policy Statement

Covered dental services and deductible amounts vary with insurance plans and are due at the time services are rendered. Please check with your insurance company if you are unsure about coinsurance or deductible amounts. Should your insurance company deny payment, you are responsible for payment of any remaining balance.

I hereby authorize the release of any medical or dental information to any agency handling my claims to secure processing and payment of benefits. I authorize that payments of benefits be made directly to Future of Dentistry for services rendered. I authorize Future of Dentistry to act on my behalf to report any suspected violation of proper claims practices by my insurance carrier to the proper regulatory agencies.

Patient/Guardian Signature:____ Date: ______________

Information Release Consent Form

I hereby authorize Future of Dentistry to use and disclose of my health/dental information including treatment plan, treatment completed and financial obligations to:

Myself Only (please circle) or print the names of people authorized to receive this information.

Name: ____ Relationship:__________________

Name: ____ Relationship:__________________