



Consent for Treatment

By my signature below, I hereby consent to and authorize any X-rays, examination, anesthetic, diagnosis, and treatment by Evergreen Dental and the dentist which is treating me. I understand that dentistry, as in all medical treatments, is not an exact science and that therefore results of any treatments performed may vary from patient to patient and cannot be guaranteed. I understand that occasionally, additional treatments, or therapies may be required following dental treatment and that I am granting my consent for any and all treatments, therapies, and procedures performed by Evergreen Dental and the dentists, hygienists, or assistants of Evergreen Dental. Also, by my signature below, I hereby certify the correctness and completeness of the medical history information which I have provided. I also understand that I am responsible for payment of all fees and costs resulting from my treatment.

Patient Signature _____ Date _____

Custodial parent or legal guardian must sign for consent if patient is a minor under the age of 18 or legally incapacitated.

If you are 18 years old or older and wish to have information about your account released to anyone additional, please sign and list them below

Patient Signature _____ Date _____

Additional people _____

Insurance information

Policy Holders Name: _____

Policy Holders Address: _____

Policy Holder's Home Phone: _____

Policy Holder's Work or Cell: _____

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Heartland Dental Ltd, dba Evergreen Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all the charges whether or not paid by the insurance. I hereby authorize Evergreen Dental to release all information necessary to secure the payment of benefits. I authorized the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____ Date _____

Privacy Practices

I _____, have received a copy of this office's privacy practices.

Patient's Signature _____ Date _____

() Patient refused to sign