Port Warwick
DENTAL ARTS
COMPREHENSIVE DENTISTRY FOR TOTAL WELLNESS, FUNCTION AND BEAUTY

Insurance Release and Consent Form

Patient's Name_____ Date of Birth_____

DENTAL Insurance Company	Phone	Name of Insured
Effective Date	Contract/ID Number	Group Number
HEALTH Insurance Company	Phone	Name of Insured
Effective Date	Contract/ID Number	Group Number

I hereby certify that the above information is correct to the best of my knowledge.

Patient Signature: _____ Date:_____

Insurance Release and Assignment of Benefits

I hereby authorize Port Warwick Dental Arts and members of its team to assist me in filing my insurance claims with my signature on file, and to furnish information to my insurance carriers concerning my (or my dependent's) treatment. I hereby assign to them payments for dental services rendered to me or my dependents, at their discretion..

Patient Signature: _____ Date:_____

Health Information Release Consent

I hereby authorize the release of information related to my (or my dependent's) health history status and treatment and copies of my (or my dependent's) health record, photographs, study models, x-rays and any test results to the appropriate individuals or agencies for healthcare professionals for medical, educational, legal or insurance purposes. I also authorize the doctor and his/her representative to consult with other Healthcare Professionals regarding my or my dependent's past or present health status whenever he/she deems it appropriate.

Patient Signature: _____ Date:_____

Treatment Consent (to be completed in office only)

I hereby authorize Port Warwick Dental Arts and members of its team to assist in performing dental treatment necessary in my care or the care of my dependent. These services may consist of, but are not necessarily limited to: x-ray examination, photographic documentation, restoration of broken or decayed teeth, administration of local anesthetic, root canal therapy, periodontal (gum) therapy, prosthetic placement of missing teeth, orthodontic tooth movement therapy, surgical extraction of teeth and other diagnostic, surgical, cosmetic and restorative procedures, as needed and/or requested by me.

I understand that the procedures to be performed are recommended in an effort to bring my (or my dependent's) teeth, oral soft tissues and supporting structures into a state of maximum health. I have been given the opportunity to discuss possible alternative treatments, if such exist and understand that dental procedures may have potential risks. I understand that in health care, the success of treatment is the result of numerous factors which include the patient's present state of dental and total body health, the degree to which a state of disease has progressed, physical or psychological tolerance for the procedures, techniques and materials used, compliance with the post-operative instructions, as well as other factors which may be exclusive of the treatment rendered.

I certify that I read and write English and I have fully read and understood the preceding text as well as other medical and dental forms and have been given the opportunity to ask questions regarding treatment and this consent form. If I do not read or write English, an individual acting as my translator has helped me understand all necessary communications.

Patient Signature: _____ Date:_____

Administrative Staff Signature:_____ Date: _____