Dakota Dental Clinic, P.A.

CONTACT / RELEASE / ASSIGNMENT

Patient Name____Date of Birth_________________

Emergency Contact (not living with you)____

Relationship_________________Home Phone________________Work Phone_________________

Whom may we thank for referring you?____

By signing below I acknowledge the information I have provided on this form and other registration forms is true and correct to the best of my knowledge.

By signing below I hereby give permission, with respect to the photographs that are taken of me at 14682 Pennock Ave, to copyright the photographs in the name of Dakota Dental Clinic, P.A., and to allow Dakota Dental Clinic, P.A., to publish the photographs, in whole or in part, in patient education material, advertising, or on your web site. I understand that in NO instance will I be identified by name.

I authorize my insurance company to remit payment directly to my dentist for services rendered. I agree that my dental records for treatment may be released to my insurance company for claims processing. I authorize the release and disclosure of any and all of my dental records to my physician, as said physician may request.

If presenting a minor for dental treatment, I acknowledge by signing below, that I have the legal authority to consent to treatment for said minor. I also agree that I am responsible for any balance not paid by insurance, regardless of custody status.

I understand that I am responsible for knowing my insurance policy coverage, and I am aware that I am responsible for any balance not paid by my insurance, and I agree to pay all statements upon receipt.

Signature____Date__________

Printed Name_____________________________________Relationship to patient_________