542 N US HWY 1, Jupiter, FL, 33469-2372

Patient Treatment Consent- Initial Visit

Patient Name: Sample Patient Id: 5814 DOB: 06/01/1987

- I authorize the dentist(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs.
- I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the dentist. The form also authorizes this practice to submit insurance claim forms and receive payment directly from the insurance carrier with the notation "signature on file". I authorize my dentist(s) to release treatment records / x-rays or any other information deemed pertinent to my insurance carrier as necessary and / or requested.
- I agree to be responsible for payment of all services rendered on my behalf or my dependents.
- Patients who have dental insurance should be aware that dental services are rendered and charged to the patient, not the insurance company. our secretary will be pleased to assist you in making your dental insurance claims by completing an attending dentist's statement for submission to your insurance company.
- I have also received a copy of this office's notice of privacy practices. I am giving my consent to use disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature of Patient
Patient, Sample
Signed on 06/26/2024 11:07:47 AM