AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

My method of payment will be _____.

_____ _____

Signature Date

In the event of an emergency, please list a contact nearby.

Name _____

Relationship _____

Home Phone # _____

Work or Cell # _____

Payment is due in full at the time of service unless prior arrangements have been made. Thank You for filling this form out completely. If you have any questions at any time, please ask; we are happy to help!