GENERAL RELEASE

- I authorize the dentist to perform diagnostic procedures and treatments that may be necessary for proper dental care.
- I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purposes of evaluating and administering claims for insurance benefits.
- I authorize the release of any information concerning my (or my child's name) healthcare, advice and treatment to another dentist
- I authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
- I understand that my dental care insurance company may pay less then the actual bill for services; I understand I am financially responsible for payments in full of all accounts. By signing this statement, I agree to be responsible for payment of services not paid, in whole or in part by my dental care payer.
- I authorize the setting up of my dental file, its follow-up, as well s my registration on the recall list(s) of the treating dentist(s)
- I have been informed that my file will be kept in the office at all times and that only the dentist(s) and his/her (their) auxiliary personnel will have access to it.
- I attest to the accuracy of the information on this registration form.

_____ _____

Signature of Patient or Parent/Guardian Date

MEDICAL/DENTAL INFORMED CONSENT

I, the undersigned, certify that I have provided, to the best of my knowledge, an accurate and complete medical & dental history and have not knowing omitted any information. I consent to my dentist obtaining from other practitioners who are currently treating me or have treated me, such further information as maybe necessary for providing me with proper dental treatment and care. I hereby promise to inform my dentist of any changes to my heath status.

_____ _____

Signature of Patient or Parent/Guardian Date

SIGNATURE ON FILE

- I authorize release to my insuring company(s) plan administrator(s) the information contained in claims submitted electronically.
- I hereby assign my benefits payable from claims submitted electronically to Dr. Archibald and authorize payment directly to him.

_____ _____

Signature of Patient or Parent/Guardian Date