OUR MISSION STATEMENT

TO PROVIDE OUR PATIENTS THE HIGHEST QUALITY CARE IN A SAFE, EFFICIENT AND COMFORTABLE ENVIRONMENT.

I authorize the dental staff to perform necessary diagnostic services, such as x-rays, study models, photographs, etc. that may be deemed appropriate by the doctor to make a thorough diagnosis.

Patient/Guardian Initials

I authorize the doctor (and his/her employees when applicable) to perform any and all forms of treatment or medication therapy, with my informed consent in connection with diagnosis and treatment.

Patient/Guardian Initials

I authorize the release of information concerning me (or my child’s) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

Patient/Guardian Initials

I authorize release of information concerning my (or my child’s) health care, advice and treatment to another dentist, should consultation be needed.

Patient/Guardian Initials

I authorize payment of insurance benefits directly to Drs. Frey and Thompson, otherwise payable to me.

Patient/Guardian Initials

I understand that my dental care insurance carrier or payor of my dental benefit may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. I understand that payment is due at the time of service, unless other financial arrangements have been made before the scheduled appointment with the Dental Office Patient Accounts Coordinator.

Patient/Guardian Initials

I attest to the accuracy of the information on the Patient Information Sheet, the Medical History, and Dental History (dated: ________________). I understand it is my responsibility to inform this office of any changes in this information.

Patient or Guardian Signature: ___________________________ Date: _______________

Nitrous Oxide Consent
I authorize the use of Nitrous Oxide.

Patient/Parent/Guardian ___________________ Date ___________________