AUTHORIZATION FORM

Registration & Medical History Consent

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and is my responsibility to inform this office of any changes in my/my child's medical status. I authorize this dental staff to perform any necessary dental services that I /my child may need during diagnosis and treatment, with my informed consent.

***Patient Signature _____
Or
Parent or Guardian (for minor child) _____
Date: _____

Financial Agreement

Payment is due in full at the time of treatment unless prior arrangements have been approved. This office accepts insurance. I understand that I am responsible for payment of services rendered and responsible for any amount my insurance does not cover.
I hereby authorize payment of the group insurance benefits otherwise payable to me directly to Great Smiles Dental. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of all information necessary to secure the payment of benefits.

***Patient Signature _____
Or
Parent or Guardian (for minor child) _____
Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy/been offered a copy of this office's Notice of Privacy Practices.

***Patient Signature _____
Or
Parent or Guardian (for minor child) _____
Date: _____

Media Essentials Consent--(*OPTIONAL***)**

I give permission to Great Smiles Dental to use my name and photo in any and all publicity efforts. I understand that submission photos may be used in any publications including but not limited to print advertisements and online publications such as Facebook and the company web page. I also grant permission for Great Smiles Dental to recognize me as they desire for awards, accomplishments, and other notable events on their company Facebook page. By signing this agreement, I relinquish any monetary claims and agree to hold Great Smiles Dental harmless for any liability arising from participation. I state that I have no conflicts of interest with the subject matter and that I enter into this media agreement of my own free will.

***Patient Signature _____
Or
Parent or Guardian (for minor child) _____
Date: _____