MEDICATION LIST

Medication: ____

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Supplements/OTC: ____

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Additional Information, Surgeries or Concerns: ____

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AUTHORIZATION

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize the release of any information concerning my health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize the release of any information concerning my health care, advice and treatment to another healthcare professional with written authorization. I hereby authorize payment of insurance benefits directly to Convergent Dentistry otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than 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 payments of services not paid, in whole or in part by my insurance carrier. I attest to the accuracy of the information on this page.

Signature X____ Date ____________________