Dental Insurance Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the above named insurance company and assign directly to Drs. Houston and Julie Tuel all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentists may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature_____Date_____

Consent for Treatment

I hereby authorize Drs. Houston and Julie Tuel or designated staff to take x-rays and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize Drs Houston and Julie Tuel to perform all mutually agreed upon treatment and to employ such assistance as is required to provide proper care. I understand that dentistry is not an exact science and that no specific results can be guaranteed. I agree to the use of anesthetics and other medications as necessary. I understand that dental procedures and the use of anesthetics and medications embody certain risks. I understand that I can ask for a complete recital of any possible complications associated with my chosen treatment.

Signature_____Date_____

Financial Policy Acknowledgment

I have received a copy of the Financial Policy. I have read, understand, and agree to this policy.

Signature_____Date_____

Privacy Policy Acknowledgment

I have received a copy of the Privacy Policy. I have read, understand, and agree to this policy.

Signature_____Date_____

Printed Name_____

Relationship to patient: Self ( ) Parent ( ) Guardian ( )