Authorizations

I have read the Dental Board of California's Dental Material Fact Sheet and Notice of Privacy Practices, and a copy has been made available to me. I, the undersigned, hereby authorize Dr. Wilson, and/or his designated employee to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Wilson to make a through diagnosis of the patient's dental needs. I also authorize the performance of any and all treatment, medication and therapy indicated based on those needs. I further authorize and consent that Dr. Wilson choose and employ such assistance as he deems appropriate. I understand that the use of anesthetic agents embodies certain risks.

I understand that responsibility of payment for dental services provided by this office for myself and/or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made in advance. I agree to pay a 1-1/2 percent per month (18 percent annually) finance charge on any balance over (30) days. In the event of default, I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. I understand that my account will be debited $50 for any returned check.

I certify that I am covered by _____ Insurance Co. and I assign directly to Dr. Wilson all insurance benefits, otherwise payable to me. I understand that I am responsible for the timely payment of my account whether or not my insurance pays. Billing problems, the result of incorrect billing information provided me, will incur a $10.00 update/rebilling fee per claim. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electric.

If an appointment must be changed I understand a twenty four (24) hour notice is required and that I may be billed a service charge of $50.00 and up for broken or missed appointments.

Declining To Sign or Altering This Form Will Result in Rocklin Dental Being Unable To Provide Services to You

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: __/__/__ Relationship to Patient:_____

Signature of patient, parent or guardian

For Office Use Only..

Health History Updates

Date	Patient Signature	Changes to Health History	Dentist Initials
__/__/__			
__/__/__			
__/__/__			
__/__/__			

Disclaimer:

Due to the changes currently being made in Dental Insurance Plans, we are strongly urging you to know the amount of your deductible or co payment, where you can be seen and the % your insurance will cover. On a daily basis our staff deals with numerous questions. They are making every attempt to keep abreast of each insurance company's rules and regulations. However you must keep in mind our ultimate goal is your dental care. Please check with your insurance company directly to verify your dental plan's covered benefits. You may contact your insurance company directly to obtain a new updated booklet regarding your dental benefits. The Dental field is ever changing; you must be a good consumer. Remember, you are responsible for your insurance coverage and their practices. Thank you for your cooperation.