PATIENT REGISTRATION
CONSENT FORM

Patient Name: _____ **Birthdate:** _____
First Name M.I. Last Name

ASSIGNMENTS OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Riverside Family Dentistry, LLC or the dentist individually for services rendered to me or my dependents by the dentist or other professional under his supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-insurance, co-pays or deductible due that Riverside Family Dentistry is unable to collect from my insurance carrier for whatever reason.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify hereby authorize Riverside Family Dentistry, LLC or the dentist individually to release any of my or my dependent's medical, dental or incidental non-public personal information that may be necessary for medical/dental evaluation, treatment, consultation or the processing of insurance benefits.

AUTHORIZATION TO MAIL, E-MAIL, CALL OR TEXT:

I certify that I understand the privacy risks of the mail, e-mail, phone calls and text messaging. I hereby authorize Riverside Family Dentistry, LLC representative or dentist to mail, e-mail, call or text me with communications regarding by dental health, including but not limited to things such as appointment reminders, referral arrangements and follow up care. I understand that I have the right to rescind this authorization at any time by notifying Riverside Family Dentistry, LLC to that effect in writing.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing and treatment as directed by Riverside Family Dentistry, LLC or his or her designee.

PATIENT SIGNATURE: _____ **DATE:** _____

GUARANTOR SIGNATURE: _____ **DATE:** _____
(If different from patient)

GUARANTOR NAME (Please Print): _____