BLAZER FAMILY DENTISTRY

# Acknowledgement

Patient Name _____

## ACKNOWLEDGEMENT

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I understand that I am responsible for payment of services rendered and also responsible for paying any patient portion that my insurance company does not cover.

**NOTE: Payment is due in full at the time of services unless prior arrangements have been made.**

Signature _____ Relationship to Patient _____

Date _____

## OFFICE USE ONLY- PATIENT PLEASE DO NOT FILL OUT

I verbally reviewed the medical / dental information provided with the patient named herein. Date _____ Initials _____

Doctor Comments: _____

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