Patient's Authorization to Release Medical Information

I understand that my family members, friends, and co-workers may ask questions about my dental treatment over the telephone or in person. I also understand it is a breach of physician-patient confidentiality for my doctors to discuss my medical information in any way with anyone without my expressed written consent. By signing this form I am designating the parties below to be able to discuss any treatments with DeMarco Family Dental.

I understand this form will be updated every calendar year. If I were to decide to make any changes regarding the release of information to any of the listed people, it is my responsibility to inform Demarco Family Dental in writing of my decision.

In accordance with the above, I (print name) _____, hereby authorize DeMarco Family Dental to discuss with and release my medical information to the following individuals:

_____ _____

_____ _____

I authorize DeMarco Family Dental to leave information regarding my care by: (check all that apply)

☐ Telephone (Voicemail) ☐ Email ☐ Fax ☐ Text

The below individuals are authorized to pick up any written document or prescriptions on my behalf:

_____ _____

Patient/Guardian Signature: _____ Date: _____

Payment Agreement

Our main goal is for you to obtain the highest quality of dental care by providing you the service that is based upon a professional, courteous and confidential working relationship between you and our office. In order to prevent misunderstandings, it is our goal to make clear all financial obligations prior to your treatment.

So we ask that complete payment is made at the time your appointment is reserved. If your treatment requires several visits, you will be given an estimate of time and cost involved. We accept major credit cards, CareCredit, checks and cash.

Patient/Guardian Signature: _____ Date: _____