

**GENERAL CONSENT TO DIAGNOSE AND TREAT:** The undersigned hereby authorizes Northview Dental of Indianapolis to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize Northview Dental Indianapolis to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that Northview Dental of Indianapolis choose and employ such assistance as deemed necessary. I understand that the use of local anesthetics agents embodies certain risk and consent to their use as deemed appropriate by Northview Dental of Indianapolis. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/ the patient's health. It is my responsibility to inform the dental office of any change in medical health or status.

**FINANCIAL CONSENT:** I understand that responsibility for payment of services provided in this office for me and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered not covered by my dental or medical insurance. I consent and acknowledge that I am responsible for all fees necessary to collect my account. I authorize Northview Dental of Indianapolis and his staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits, and to handle any necessary claim appeal(s).

**Consent (Adult):**

Name of patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

**Consent (for a minor child):**

Name of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

**Notice of Privacy Practices (below)**

Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health Information ("PHI") and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. By signing below you are acknowledging receiving notice of our practices' policies and your rights regarding PHI. I allow release of pertinent medical records to my insurance company (if applicable), my other dental or medical providers and family or non-family members listed below.

\_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

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