BURKHART DENTISTRY
COSMETIC, IMPLANT & FAMILY CARE

EXAMINATION, RECORDS AND FINANCIAL CONSENT

EXAMINATION CONSENT

I, _____, hereby authorize the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor. I am fully responsible for all dental fees, and these fees are due and payable at the time of service unless prior financial arrangements are made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late fee may be added for any overdue balances. I understand that credit reports may be obtained where appropriate.

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OFFICE FINANCIAL POLICY

I, _____, have read and acknowledge the practice financial and insurance policy.

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RELEASE OF RECORDS

I, _____, authorize release of any current dental records including radiographs, study models and photos to Bill Burkhart, D.D.S. at the address below.

_____ _____

Printed Name of Patient Signature of Patient or Guardian

4005 Spicewood Springs Rd. Suite A-100 – Austin, Texas 78759
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