Responsibility for Balance

I understand that I am responsible for any balance incurred for any dental services rendered by any dental provider in this office, regardless of estimated insurance benefits. I understand that any estimate given to me regarding my insurance coverage or dental treatment is just an estimate and subject to change when reviewed by my insurance company. I understand that my insurance, if I carry insurance, can change, deny, or recode any dental treatment according to their contracts with my employer.

Signature____________________________________ Date ________________
(Parent's Signature if Minor)

Insurance Assignment of Benefits

I hereby authorize payment of any dental benefits issued by my insurance company directly to Dr. Stephen R. Feit.

Insured's Signature____

Consent to treatment

I request and authorize Dr. Stephen Feit, and/or such other persons as he appoints, to perform or assist in the performance of needed dental treatment. I understand that this is for the purpose of, but not limited to, one of the following: diagnosis, pain, decay, periodontal disease or treatment, restorable, or non-restorable teeth, and any other conditions of the mouth. I further consent to any needed x-rays, medications, or referrals that might be necessary to correctly diagnose or treat my condition. I consent to, and authorize the performance of, any additional care, procedure, or treatment not specified above that the dentist believes necessary, as a result of unforeseen events or conditions. I understand that there have been no guarantees given or implied of any sort by anyone as to the results that may be obtained. I consent to the administration of any anesthetic deemed necessary and I understand the risks, including but not limited to, bruising, swelling, temporary or permanent numbness, sensitivity reaction, etc. I have been given the opportunity to refuse to consent to any and all treatments proposed by not signing this document or by resending this signature in writing, at any time. I understand that this is a general consent form and that I may be required sign more specific consent forms based on the treatment that is proposed. I understand that my consent to dental treatment is also a consent to dental charges for which I am fully responsible. I certify that I have read and understand the above; I accept all risk in the hope of obtaining the desired beneficial results.

Signature____ Date______________
(Parent's signature if minor)

(Please continue to final consent sheet)

Please detach the bottom portion for your records