

Michael E. Kanefsky, D.M.D. Marc I. Moscowitz D.M.D. Carmine Corigliano D.M.D.

The Dental Center

731 Bloomfield Avenue

Bloomfield, New Jersey 07003

973-743-5116

Consent:

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (patient's name)_____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for my dependants is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 ½ % finance charge (18% APR) may be added to my account in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information given on my medical history form.

Patient_____Date_____Witness_____

Parent or Responsible Party_____Relationship to Patient_____

Insurance Patients Only:

As a courtesy to you, we will accept your insurance as full or partial payment toward your account. Prior to each and every visit, we will "Guesstimate" the amount that your insurance plan does not cover and we would appreciate your share being paid at the time of treatment. If however your insurance company rejects any portion of your claim, you will be billed for the outstanding balance. The ultimate responsibility of payment to this office is yours.

I hereby authorize the above named dentist(s) to provide any insurance company(s), claim administrator(s), and consulting health care professionals, information concerning health care, advice, treatment, or supplies provided. This information will be used exclusively for the purpose of evaluating and administering claims fro benefits.

Patients or

Authorized Guardian's Signature_____Date_____