PATIENT NAME:_____

PRIVACY PRACTICES:

** I have read and accept the Privacy Practices of Dr. John C. Winskill DDS PS. I understand my rights under the Health Insurance Portability & Accountability Act.

X_____ Date:_____

AUTHORIZATION AND RELEASE:

** I certify that I have read and understand the patient information form to the best of my knowledge. The questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Dr. John C. Winskill to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Dr. Winskill otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ Date:_____

CONSENT FOR DENTAL TREATMENT:

I authorize Dr. Winskill and his staff to perform routine dental care on myself/child. Dr. Winskill will explain any restorative treatment that is needed along with alternative treatment. Unforeseen conditions may arise during the procedure that require a different procedure than set forth. I therefore authorize Dr. Winskill and staff, to perform such procedures when, in their professional judgment, they are necessary. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor chooses and employ such assistance as deemed fit to provide recommended treatment.

X_____ Date:_____