Date_____

TREATMENT CONSENT

I hereby authorize Dr. Michael Holden or designated staff to take x-rays, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis. I also give consent to doctor or designated staff to perform all recommended treatment mutually agreed upon.

I agree to be responsible for payment of all services rendered. I understand payment is due at time of service unless other arrangements have been made.

I give consent for my treatment, billing/insurance or appointments to be discussed with the following individuals: (Spouse, parent, adult child, care giver)

_____

(*Please print names*)

Patient Signature _____

Treatment Consent for Minor Child

Parent/Responsible Party's Signature_____

INSURANCE INFORMATION

****Please supply your DENTAL insurance cards for copying****

Primary DENTAL Insurance Company_____

Name of Policyholder_____ Date of Birth_____

Social Security Number_____ Policy/Group Number_____

Identification Number _____Employer or Retired from_____

Secondary DENTAL Insurance Company_____

Name of Policyholder_____ Date of Birth_____

Social Security Number_____ Policy/Group Number_____

Identification Number _____Employer or Retired from_____