GILCHRIST DENTAL CARE
ADMISSION TO THE PRACTICE AGREEMENT

I consent to routine dental procedures as well as treatment and diagnostic tests deemed necessary in the dental professional's judgment.

I authorize the dentist and staff of Gilchrist Dental Care to take and record any photographs of me for records, teaching, research and publication purposes. I understand that in any publication my name will not be identified.

I authorize Gilchrist Dental Care to take any x-rays necessary for the detection and diagnosis of oral diseases, and I authorize the release of this and any other information to my insurance company necessary for the processing of my dental claim (if applicable).

I authorize Gilchrist Dental Care to administer local anesthetics and medically indicated drugs as necessary for treatment.

I authorize the payment of my group insurance benefits, otherwise payable to me, to Gilchrist Dental Care.

I understand that I am responsible for payment of my treatment, regardless of insurance coverage. I understand that Gilchrist Dental Care as a courtesy to me may estimate my expected insurance portion, **but this is not a guarantee of payment from my insurance company.**

_________________________________ ______________________

Signature (Patient or Legal Guardian) Date

Insurance

Gilchrist Dental Care will be happy to file any insurance as a courtesy to you. When possible, we try to estimate your expected insurance benefit for each procedure planned. Remember that these are estimates to the best of our ability. If you receive any request for information from your insurance to process a claim, please respond promptly so they can expedite this processing in a timely manner.

If you have any questions about your claim or the information that they request, please contact us, and we will be happy to help you in any way we can.