

SIGNATURE ON FILE

I hereby consent to the taking of x-rays , photographs and other necessary records before, during and after treatment and to the use of the same by this practice for scientific papers and demonstrations.

RESPONSIBLE PARTY

DATE

I also authorize the release to my insurance company or companies any information including the diagnostic records and diagnosis of any treatment required to comply with applicable law and facilitate the billing and reimbursement for treatment provided.

Insurance Co.: _____ Group # _____

Insurance Co.: _____ Group # _____

Employed By: _____

SIGNATURE OF PARTY #1

DATE

Insurance Co.: _____ Group # _____

Insurance Co.: _____ Group # _____

Employed By: _____

SIGNATURE OF PARTY #2

DATE

