X-RAY CONSENT

I authorize Owen Family Dentistry to take all necessary X-RAYS AND STUDY MODELS as needed to make a thorough diagnosis.

I authorize Owen Family Dentistry to PERFORM ALL RECOMMENDED AND AGREED UPON TREATMENT. I also authorize the use of anesthetics (as needed) and I am fully aware that using anesthetic agents involves certain risks.

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Signature/Responsible Party **Date**

INSURANCE INFO

OWEN FAMILY DENTISTRY IS HAPPY TO FILE YOUR INSURANCE AS A COURTESY.

PLEASE BE AWARE, DENTAL BENEFITS ARE DIFFERENT FOR EVERY INSURANCE PLAN.

IT IS YOUR RESPONSIBILITY TO BE FAMILIAR WITH THE DETAILS OF YOUR INSURANCE COVERAGE. WE WILL HELP ALL WE CAN, BUT CANNOT ALWAYS VERIFY DETAILS OF INDIVIDUAL CONTRACTS IN OUR OFFICE.

WE WILL TRY TO COMPLY WITH INDIVIDUAL POLICY RESTRICTIONS BUT WE MUST ALWAYS RECOMMEND THE CARE THAT WE FEEL IS BEST, DESPITE A POSSIBILITY OF INCREASED COST TO YOU.

By signing below, I hereby acknowledge and understand my responsibilities as an insurance policy holder. I understand that I as a patient am ultimately responsible for payment for all services rendered by Elite Dentistry at the time of treatment, and shall pay for any services not covered by my insurance company.

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Signature of Responsible Party **Date**