

Patient Name: \_\_\_\_\_

### GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and dental-medical history of myself/my dependant and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding the dental-medical history of myself / my dependant. I understand that withholding any information could seriously jeopardize my safety. I will also advise this dental office should there be any change in my/my dependant health status in the future.

I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary and I consent to the release of this information.

I have also review the Privacy Policy explaining how your office will use my personal information, and the steps your office is taking to protect my information. I know that your office has a Privacy Code, and I can ask to see the Code at any time. I agree that the dental office of Dr. Ricky See can collect, use and disclose my personal information as set out in the office's privacy policies.

I also understand that the policy of this dental office requires that I provided them with at least 48 hours advance notice should I be unable to keep my scheduled appointment or a cancellation charge will apply for each appointment cancelled.

I understand that responsibility for payment of the dental services for my dependents and myself is mine. By agreeing to proceed with treatment, I assume responsibility for paying the full fees for all dental services I and my dependents received in this office disregarding any benefits that I might or might not be able to receive from my insurance carrier.

X \_\_\_\_\_  
Signature: Patient( ) Parent( ) Guardian( )

\_\_\_\_\_  
Print name of guardian

Date : \_\_\_\_\_