FAMILY & COSMETIC DENTISTRY OF THE ROCKIES

DR. TRAVIS R. WILLEY, D.D.S.
DR. BRANDON M. MURRI, D.M.D.

DATE _____

PATIENT NAME: _____

ADDRESS: _____

_____

PHONE HOME #_____WORK#_____CELL#_____

CONSENT FOR TREATMENT

1. I hereby authorize doctor and authorized staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs.
2. Upon such diagnosis; I autherize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand taht I can ask for a complete recital of possible complications.

Patient:_____ Date: _____

Parent or Responsible Party: _____

Relationship to the Patient: _____

HIPAA CONSENT

HIPAA PRIVACY STATEMENT, INSURANCE AND DENTAL RELEASE

I have been provided a copy of Family and Cosmetic Dentistry of the Rockies, Privacy Statement to read. If I would like a copy of the policy I may request a copy today or any time in the future by stopping the office during normal business hours.

NAME:_____ DATE _____

I hereby authorize Family and Cosmetic Dentistry of the Rockies, to furnish my insurance company copies of my x-rays and records of my charts if requested for reimbursement.
I understand I am financially responsible to Family and Cosmetic Dentistry of the Rockies for all charges, including those not covered by my insurance.

NAME:_____ DATE _____