

Dr. Trudi Massaro
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Seminole, FL 33776
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Release Form

I authorize the dentist and those appointed by the dentist as her assistants to perform diagnostic procedures and treatment as may be necessary for proper dental care.

In connection with the dental services which I am receiving, I authorize the taking of dental photographs. These photographs are for in-office use only and are used for the purpose of documentation, treatment planning, communication with our lab and education.

I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I authorize that I am responsible for all costs of dental treatment.

I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me.

I attest to the accuracy of the information on this form.

By signing this form, you acknowledge that you understand everything that you have read and that the questions you have answered are true.

Patient or Guardian's Signature: _____ Date: _____

Appointments

We welcome you to our office. We will do our best to make your appointments as convenient and pleasant as possible. We will be happy to assist you in filing the necessary forms for your insurance reimbursement. If at any time you have any questions regarding your treatment, your appointments, or fees, please feel free to ask. We value your opinion and want to provide you with the best possible care.