DESIGNATED RELATIVE

I authorize discussion and release of my general dental condition and diagnosis (including treatment, payment, and healthcare operations) with relative(s) listed below. Please list family members or significant others, if any, whom we may inform about your dental condition, and/or in case of an emergency. This authorization will remain in effect until revoked in writing.

Name:_____________________Relationship:_____________Phone #__________

Name:_____________________Relationship:_____________Phone#__________

Name:_____________________Relationship:_____________Phone#__________

Messages may be left on my answering machine regarding my dental health & appointment made ( ) Yes ( ) No

AUTHORIZION FOR ASSIGNNMENT OF BENEFITS

I hereby authorize Dr. Zollo to furnish information to my insurance company concerning my care. I further hereby assign all payments for dental services rendered to me, or my dependents, by my insurance company. I understand that I am fully responsible for any portion of these services not covered by my insurance benefits.

Print Patients Name:_____________________________

IF A MINOR, PARENTS/GUARDIAN RESPONSIBLE FOR THE BILL

PRINT:_______________________________________

SIGNATURE:__________________________________

WK#___________________HM#__________________

ADDRESS____________________________________

CITY______________________STATE________ZIP__________

Date:____________