Authorization and Release

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize 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.

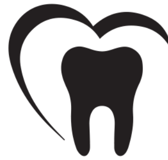
I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payer.

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

X ______________________________________

Signature of patient (or parent if minor)



Elizabeth Kilpatrick-Fox, D.M.D.
1507 Kings Highway
Swedesboro, NJ 08085
(856) 467-1100

Our Convenient Office Hours

Mondays	9:00 a.m. to 5:00 p.m.
Tuesdays	9:00 a.m. to 5:00 p.m.
Wednesdays	9:00 a.m. to 1:00 p.m.
Thursdays	9:00 a.m. to 6:00 p.m.

If you have an emergency someone is on call 24 hours a day.
Just call our office and listen for the emergency instructions.