



NEIL W. BROWN, D.D.S.  
DENTAL PERMISSION

*We have found that correspondence with our patients via email, cell phone and text have been very successful.*

\_\_\_\_ May we call your cell phone?      \_\_\_\_ Do you check your messages?

\_\_\_\_ Are you willing to receive a text message from us?

\_\_\_\_ May we correspond via email? How often do you check your emails? \_\_\_\_\_

**Email Address** \_\_\_\_\_ **Cell Phone #** \_\_\_\_\_

*Please initial the following:*

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

\_\_\_\_ I authorize Dr. Brown to perform diagnostic procedures and treatment as may be necessary for proper dental care.

\_\_\_\_ I authorize release of any records concerning my (or my child's) health care, for the purpose of evaluating and administering claims for insurance.

\_\_\_\_ I authorize payment of insurance benefits directly to Dr. Brown, otherwise payable to me.

\_\_\_\_ I understand that my dental insurance benefit is an estimated amount and rarely covers all costs of treatment. I am responsible for payment of services not paid, in whole or in part, by my dental insurance. I understand I am financially responsible for payments in full of all accounts.

**Patient's or Guardian's Signature** \_\_\_\_\_

**Social Security Number** \_\_\_\_\_ **Driver's License** \_\_\_\_\_

**Date** \_\_\_\_\_