



College of Dentistry

Certification and Authorization

AUTHORIZATION FOR TREATMENT: I hereby certify that I can read, write and understand the English Language and hereby consent to and authorize the University of Florida College of Dentistry dentist to perform any tests or treatments that in their judgment are considered necessary and advisable for the detection, diagnosis and treatment of oral diseases. Patient's Initials (Parent or Guardian) _____

I understand that UFCD's policies regarding infectious diseases are available to me upon request. I authorize the dentist to administer local anesthetics and other medically indicated drugs or pharmaceuticals and to use dental materials they deem necessary for such operative and technical procedures necessary to complete a diagnosis and/or recommended treatment. Patient's Initials (Parent or Guardian) _____

CONSENT TO BE PHOTOGRAPHED: I authorize the dentists and staff of the UFCD to take and record, with the approval of my dentist, photographs, movies, audio and videotapes of me for the records, teaching, research and publication purposes. It is specifically understood that in any publication or use I shall not be identified by name. Patient's Initials (Parent or Guardian) _____

I understand the photographs, movies, audio, and videotapes of me may be modified or retouched in any way that my dentist in his/her discretion may consider desirable. I further understand that publication of any photograph in any form which depicts my likeness and/or is recognized to be me shall be done only with my expressed written permission. Patient's Initials (Parent or Guardian) _____

PAYMENTS OF BENEFITS: I Authorize payment of benefits, as determined by the insurance company, directly to the surgeon or dentist True . I understand that unless I have checked YES above, benefit payments will be paid to me. I also understand that I may be responsible for any amounts not paid by the insurance company to the surgeon or dentist. Insurance is not accepted in the undergraduate programs. Patient's Initials (Parent or Guardian) _____

RELEASE OF INFORMATION: I hereby authorize the UFCD and treating physicians to release information to my insurance companies for my treatment and care and, if requested, to my referring physician or any healthcare facility period of illness, and other information as may be required to secure payment for charges incurred by me or in my behalf including a diagnosis of my condition. Patient's Initials (Parent or Guardian) _____

GUARANTOR AGREEMENT: I hereby agree to pay all charges connected with this treatment. I understand that insurance coverage or sponsorship does not release me from the obligation to make payments in accord with the policies of the UFCD clinics. Patient's Initials (Parent or Guardian) _____

I hereby acknowledge by my signature that I have fully read and authorized all sections indicated by initials above.

Date

Date