INFORMATION VERIFICATION

By signing below, I verify that the above information is correct to the best of my knowledge. I will not hold my doctor, or any staff members, responsible for any errors or omissions that I have made in the completion of this form.

X_____ **X**_____

Signature of Patient (Parent or Guardian if Minor) **Date**

FINANCIAL POLICY

Payment is expected on the date of service unless other financial arrangements have been made prior to the appointment. I agree to pay any balance incurred by services rendered. If using dental insurance, I authorize the release of any information regarding treatment to my insurance company, and that benefits be paid directly to Pullman Family Dentistry, PLLC. I understand that any patient portion that is estimated based on my dental insurance plan may change once the insurance claim has processed, and that I am responsible for any balance not paid by my dental insurance.

X_____ **X**_____

Signature of Patient (Parent or Guardian if Minor) **Date**

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X_____ **X**_____

Signature of Patient (Parent or Guardian if Minor) **Date**

Reviewed by: _____ **Date:**_____