Rhode Island Endodontics
Usman Fazli, DMD
Diplomate, American Board of Endodontics
Fellow of Royal College of Dentists Canada

General Consent Form

PATIENT INFORMATION

First Name		Last Name		Birth Date	

ASSIGNMENTS OF INSURANCE BENEFITS

I hereby authorize direct payment of my insurance benefits to **Usman Fazli DMD PC** doing business as **"Rhode Island Endodontics"** or the dentist individually for services rendered to me or my dependents by the dentist. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any coinsurance, co-pays or deductible due that Rhode Island Endodontics is unable to collect from my insurance carrier for whatever reason.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION

I certify hereby authorize **Usman Fazli DMD PC** doing business as **Rhode Island Endodontics** or the dentist individually to release any of my or my dependent's medical, dental or incidental non-public personal information that may be necessary for medical/dental evaluation, treatment, consultation or the processing of insurance benefits.

AUTHORIZATION TO MAIL, E-MAIL, CALL OR TEXT

I certify that I understand the privacy risks of the mail, e-mail, phone calls and text messaging. I hereby authorize **Rhode Island Endodontics** representative or dentist to mail, e-mail, call or text me with communications regarding my dental health, including but not limited to things such as appointment reminders, referral arrangements and follow up care. I understand that I have the right to rescind this authorization at any time by notifying Rhode Island Endodontics to that effect in writing.

CONSENT TO TREATMENT

I hereby consent to evaluation, testing and treatment as directed by Rhode Island Endodontics or his or her designee. This will include Dental Examination, digital dental radiographs and in some cases advanced cone beam computed tomography (CBCT) imaging.

FORM COMPLETION

Signature of	❑ Patient ❑ Legal Guardian	❑ Parent ❑ Agent Under Durable Power of Attorney	
Printed Name	*First Name*	*Last Name*	
Signature of Patient, Parent or Guardian		**Date**	