- **I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for my balance regardless of my insurance benefits.**
- **I authorize release of any information relating to my dental claims**

X_____ _____

Signed (Patient OR Parent if a minor) **Date**

- **I assign dental benefit payments to be paid directly to Crist & Wenande Orthodontics from my insurance company.**

X_____ _____

Signed (Patient OR Parent if a minor) **Date**

- **I give permission for my orthodontist and his/her clinical team to take any necessary x-rays, photos or study models to enable complete diagnosis and treatment.**

X_____ _____

Signed (Patient OR Parent if a minor) **Date**

3500 S. Marion Rd.
Sioux Falls, SD 57106
605-361-0016

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Sioux Falls, SD 57103
605-271-8828

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