JOURNEY
• ORTHODONTICS •

- 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