tel: 954 236 5273
info@mytoothtales.com

CREDIT CARD AUTHORIZATION FORM

I ______________________ give permission for Tooth Tales to charge my credit card without being present.

Patient's Name: ______________________

Pedo Account# ______________________ Ortho Account #: ______________________

Name on credit card: ______________________

Credit card number: ______________________

Expiration Date: ______________________ CID number: ______________________

Amount of the charge: ______________________

One Time Charge

Recurring Charge:

Date of recurring charge: ______________________ Effective Date: ______________________

Signature: ______________________ Date: ______________________

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PATIENT RECORD RELEASE FORM

Date: ______________________________

Patient's Name: ______________________________ D.O.B.: ______________________________

I ______________________________ , request the dental records and dental radiographs taken on my child to
(Parent/Guardian Name)
be released to me.

Parent's Signature: ______________________________ Date: ______________________________

OFFICE USE:

Date Released: ______________________________

Method of Release: ○ Mail ○ Parent Pick-up ○ Email

Released by: ______________________________

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PARENT NOT PRESENT

I ______________________ (Parent's Name), the parent of ______________________ (Child's Name) give Tooth Tales permission to treat my child while I am not present. The individual bringing my child to the appointment is named, ______________________ (Name of Individual), the ______________________ (Relationship to child) of the child and is 18 years or older of age. I also give this individual permission to make decisions regarding my child's dental treatment, medical treatment (if necessary should an emergency arise) and behavior management.

Signed: ______________________ Date: ______________________

Relationship of Patient ______________________

PLEASE ATTACH A COPY OF PARENT'S DRIVER'S LICENSE: