

## Health Certification & Consent

Dr. Steven Blaustein  
18 Hilliard Avenue  
Edgewater, New Jersey 07020  
(201) 941-9666

Date: \_\_\_\_\_

Age: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

**Health Certification:** By signing the health questionnaire, I certify that I have answered every question and filled in every blank. I further certify that I have asked for assistance in answering every question I was unsure about or did not understand. To the best of my knowledge, the answers to these questions are complete and accurate. In addition, I agree to inform the Dentist whenever there is a change in my health.

**Consent:** I hereby authorize and request the performance of dental services for myself or for the patient identified above. I also give my consent to any advisable and necessary dental procedures and have been informed of all the consequences of the treatment, medications or anesthetics to be administered by the attending dentist or by the dentist's supervised staff for diagnostic purposes or for treatment. I authorize the dentist to release health information about me (including x-rays) and information about my dental treatment to other health professionals and to insurance companies.

**Financial Responsibility:** I understand and acknowledge that I am financially responsible for the services provided for me the patient identified above, regardless of insurance coverage.

Person completing the health questionnaire: \_\_\_\_\_

If the health questionnaire was not completed by the patient, please provide the following information:

\_\_\_\_\_  
Signature of Patient ( or guardian if minor)

\_\_\_\_\_  
Print Name