Barry S. Edland, DDS, PA

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301-662-5441

Patient Authorization

I authorize the Dentist or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist or designated staff member to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist and mutually agreed upon by me.

I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy (s) to the Dentist. This form also authorized the Practice to submit insurance claim forms and receive payment directly from the insurance carrier with the notation "SIGNATURE ON FILE". I authorize my Dentist to release treatment records, x-rays or any other information deemed pertinent to my insurance carrier as necessary and/or requested. I also acknowledge that my Insurance Policy/Plan is a contractual relationship between my employer/self and my insurance company.

Patient Name_____

Patient/Parent/Guardian Signature_____

Date_____