

CONSENT FOR TREATMENT

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I have read all the information on both sides of this sheet and have completed the answers on this form. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or any changes to the my personal information.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account, or my dependents, for any professional services rendered. I understand that payment is due at the time of service unless other arrangements have been made in advance. In the event that payments are not received by agreed upon dates, I understand that a 1 1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Signature

Date

Parent (if minor)

Date

Witness