CONSENT FOR TREATMENT

1. 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 (patient)_______________________________’s dental needs.

2. 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.

3. 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.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1½% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

5. As a courtesy to all patients our staff will confirm your appointment 1-2 days before your scheduled date. However, we expect appointments to be kept with or without a courtesy call. If an appointment needs to be broken we ask that you advise the office at least 24 hours in advance. Please note that a fee may be charged if 24 hours notice is not given.

6. I grant my permission to you or your assignee to contact me at home or at my work to discuss matters related to this form.

Patient Signature ____ Date ___________________________

Parent/Responsible Party Signature __________________________________Relationship to Patient ___________