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This consent form must be filled out completely before any treatment can be rendered. Thank you for your cooperation.

Consent:

1. I _____ hereby authorized doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.

2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for treatment. I understand that using anesthesia agents embodies a certain risk. Furthermore, I authorize and consent that doctor
choose and employ such assistance as deemed fit to provide recommended treatment.

3. I understand that all responsibility for payment for dental services provided in this office for myself or my other dependents is mine, due and payable at the time services are rendered unless other arrangements have been made.

4. I understand that it is my responsibility to advise your office of any changes in the Information obtained on this form.

5. I authorize the use of my social security number to file my dental claim if applicable.

6. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment, deductibles, and remaining balance that my insurance does not cover.

7. I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence.

Patient:_____ Patient Social Security Number:_____

Responsible Party:_____Relation to patient:_____

Responsible Party Social Security Number:_____

Responsible Party Signature:_____ Date:_____

Witness Signature:_____ Date:_____