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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 authorize the doctor to order x-rays, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of 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 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 dependents is mine, due and payable at the time services are rendered unless 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 is applicable.
6. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying co-payment, deductibles and remaining balance that my insurance did 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patients Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party Social Security#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_