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 (name of patient) ____________________________________’s dental needs
2. Upon 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 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 even payments are not received by agreed upon dates, I understand that a 1.5% late charge (18% AOR) may be added to my account.
5. I understand that any insurance or reimbursement program is a contract solely between me and that company. I understand that I am ultimately responsible for my accounts regardless of insurance payment.

PATIENT’S SIGNATURE: ________________________

DATE: _____________

PARENT/RESPONSIBLE PARTY’S SIGNATURE: _________________________

RELATION TO PATIENT: __________________________

This information is NOT shared with anyone outside this office. This material is strictly confidential and collected soley for the use of this office to process your medical/dental records chart. This data will be stored in your dental record. This information will not be shared with anyone without written consent that is signed and dated only by you

The Art of Dentistry
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