

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 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 understand that if I decline to undergo treatment, delay treatment, or fail to keep my appointment (s), I accept that there may be permanent irreversible damage to my dental health.

\_\_\_\_\_ Please initial

4. I agree to the use 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.
5. 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 1.5% late charge may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's

Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Parent/Responsible Party's Signature \_\_\_\_\_

Relationship to Patient \_\_\_\_\_