Dental Consent Form

The undersigned hereby authorizes doctor to take x-rays, study models, photos, or other diagnostic aids appropriate by doctor to thoroughly diagnose the patient's dental needs.

I also authorize doctor to perform all treatment recommended mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.

In the event that any necessary dental records need to be transferred to another dental provider, signature of this form will enable us to forward any records pertaining to your care.

I understand that all responsibility for payment for dental services provided in this office for me or my dependents of mine, due and payable at the time of services are rendered unless other arrangements are made. In the event payments are not received by the agreed upon dates, I understand that a 1-1.5% finance charge (18% charge APR) may be added to my account. I also understand where appropriate, a credit bureau report my be obtained.

Patient: _____ **Date:** _____

Witness: _____

Parent/Responsible Party: _____

Relationship to Patient: _____