

Standard Dental Treatment Consent Form

We are complimented that you have selected us to provide dental care for you.

The undersigned hereby authorizes doctor to take 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.

I authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medications 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.

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 other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a one and a one half percent monthly finance charge (18% APR) will be added to my account, and I agree to pay it.

I understand and agree that where appropriate, credit bureau reports may be obtained.

Patient

Date

Witness

Parent or Responsible Party

Relationship to Patient