All Smiles Children's Dentistry
Dr. Houri Fatourachi, DDS
2325 South Melrose Dr.
Vista, CA 92081
Tel: 760-734-4400
Fax: 760-734-4454
drhouri@drhouri.com

Consent for Dental Treatment

Child's name: Date of birth:

Please read carefully. Please do not hesitate to ask us about anything that is unclear to you.

I HEREBY AUTHORIZE DR. HOURI FATOURACHI TO PERFORM ANY AND ALL TREATMENT FOR THE ABOVE MENTIONED CHILD AND CONSENT TO SUCH METHODS, DRUGS AND AGENTS AS MAY BE INDICATED IN CONNECTION WITH HIS/HER DENTAL CARE. IN GENERAL TERMS THIS MAY INCLUDE, BUT NOT BE LIMITED TO:

Examination and X-rays, Cleaning and Fluoride treatment.
After being informed and accepting a treatment plan: Administration of local anesthetic, Fissure sealants, Dental restorations, Space maintainers, removal of teeth, Treatment of injured oral tissue.
Various methods of behavior management in the case of apprehensive of pre-cooperative child: Tell-Show-Do method: Detailed verbal and visual explanation.
Voice control management: Firm verbal instructions.
Patient stabilizing system: Mesh and Velcro wrap blanket; a passive restraint used to control unsafe patient movements.
Administration of sedative medication, if indicated, would be discussed in detail prior to use.
This consent shall remain in effect until canceled.

Signature Date of Birth:

Print name: Relation to child:

Financial Policy and Dental Insurance

Our goal is to provide you with the best possible care. Having a good professional doctor-patient relationship is based on mutual respect and understanding. A dental fee includes the doctor's special training skill, care and judgment, uses of trained auxiliary personnel, material and equipment. In order to achieve our goals we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered, unless our staff has approved payment arrangements in advance. Returned checks will be charged $25.00 fee upon notification to us by the bank. Balances older than 30 days may be subject to additional fees and/or interest charges of 1½% per month. All charges are your responsibility from the date the services are rendered. Filing of insurance claims is a courtesy that we extend to our patients.

I hereby authorize payment directly to Dr. Houri Fatourachi of the group Insurance benefits otherwise payable to me but not to exceed the charges for treatment. I understand that I am financially responsible for any charges not covered by this authorization. I hereby accept the foregoing treatment plan and authorize release of any information to this claim.

Responsible Party Date of Birth: