CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriated by doctor to make a through diagnosis of my or the 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 agree to the use of 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.
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 event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account.

Patient's Signature_____Date_____

Parent/Responsible Party's Signature_____

Above Relation to Patient_____

CONSENT FOR USE OF DENTAL PHOTOS

1. I hereby authorize the doctor or designated staff to use photos for educational or advertising purposes. I may rescind permission for photo use in writing at any time.

Patient's Signature_____

Date_____