Patient Agreement and Consent

I certify that I have read, understood and agree to the above outlined office financial policy and patient obligations. I request Dr. John Eberz evaluate and advise me of any and all dental procedures necessary for the restoration and maintenance of my oral health. I understand that I am financially responsible for all charges, whether or not paid by my insurance carrier on all work performed by this office.

Patient's Signature:
(guardian if patient is a minor)

Date: