INFORMED CONSENT

1. I hearby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of _____'s dental needs.
(Patient's name)

2. Upon such diagnosis, I authorize the 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 medications 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 dependents. I understand that payment is due at the time of service unless other arrangements have been made

5. Lastly, I agree to notify the office 24 hours in advance in case I am unable to keep a scheduled appointment. If I am unable to do so, I understand that cancellation fees might apply.

_____ _____

Patient or Responsible Party's Signature Date

Responsible Party's Name: _____

Relationship to Patient: _____