

PRECISE DENTAL CARE – CONSENT FOR TREATMENT

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1. I hereby 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' Name: _____

Relationship to Patient: _____