Consent for Services

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids appropriate for a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform treatment mutually agreed upon and to use medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that anesthetic agents involve a certain risk. Furthermore, I authorize doctor to choose and employ assistance as deemed fit to provide treatment.
3. I understand that responsibility for payment of services -- for me, or my dependents -- is mine, due and payable at the time services are given unless other arrangements are made. In the event that payments are not received as agreed upon a monthly 1 % finance charge may be added to my account.
4. I understand that, if needed, a credit report may be obtained. If my account goes to collections, a minimum fee of $50, or 5% of the total deliquent balance, will be charged to cover collection expenses.
5. I understand it is my responsibility to advise of any changes regarding my name, residence, phone numbers, dependents, employer, or insurance benefits. I grant permission to doctor, or staff to phone me at home, or work to discuss matters related to this information.

I have read the above conditions and agree to their content.

Signature: _____ Date: _____ Relationship to Patient: _____
(of patient, parent, or guardian)

Date of Service:	*Type of Service:*	*Patient Signature:*

The results of dental treatment are not always predictable. Reputable practitioners cannot guarantee results. I acknowledge that no guarantee has been made by anyone regarding treatment I have authorized. I also understand my treating dentist is responsible for my treatment and that alternatives -- including no treatment -- have been discussed and are understood.