



1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of _____'s dental needs.
(name of patient)
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon 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 inquire about 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. If required, I also understand a check of my credit history may be made, and that I will be responsible for costs and attorneys fees if this is sent to collection.

Patient's Signature _____ Date: _____ Witness: _____

Parent/Responsible Party's Signature _____ Relationship to Patient: _____