Consent To Treatment

Cancellation Policy:
A fee will be charged for less than 24 hours notice if cancelling an appointment.

Authorization:

If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. To the best of my knowledge, all of the preceding information is true and correct.

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 ask for a complete recital of any possible complications.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependents(s) to third-party insurance carriers, payors, and / or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that aren't fully covered by insurance, and I may be billed for the remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Print the name of the patient, parent, or guardian:

Printed Name: _____
First Mi. Last

Signature of patient, parent, or guardian:

Signature: _____ Date: _____

Relationship To Patient: _____