Family Dentistry
Where Beautiful Smiles Are Created
Cosmetic, Orthodontic & TMJ Treatment

CONSENT FOR TREATMENT

Patient Name: _____
Preferred to be called: _____

- I hereby authorize the 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

- Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

- 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.

_____ _____
Patient's Signature Date

_____ _____
Parent/Responsible Party's Signature Date

In the event of an emergency, whom should we contact?

Name: _____
Relationship: _____
Phone #: _____ Cell #: _____