Payment &Treatment Consent

I authorize the doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to thoroughly diagnose dental needs of _____.I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I give my consent to use local anesthetics, relaxants, analgesia ("laughing gas"), antibiotics, or pain medication if deemed necessary for the completion of any dental treatment. I understand that the use of anesthetic agents embodies a certain risk. I also understand that responsibility for payment for dental services provided by this office for myself or my dependents is mine, due and payable at the time services are rendered unless other financial arrangements are made. In the event of default, I (we) promise to pay interest at the rate of 1.5% monthly on the indebtedness, together with all collection costs and reasonable attorney fees as may be required to effect the collection of this note. ***FEES NOT PAID BY THE INSURANCE COMPANY WITHIN 60 DAYS ARE PAYABLE FROM THE PATIENT OR THE RESPONSIBLE PARTY.***

Signature of Responsible Party _____Relationship to Patient_____ Date:_____

Authorization

I hereby authorize my insurance benefits to be paid directly to the doctor's office and also authorize the doctor to release any information to process insurance claims.

Date_____ Signature (Insured)_____

Dental Services Acknowledgement

- I understand that whenever a tooth is extracted, there is a possibility of infection, bone fracture, temporary paresthesia (numbness) of the lip, gum, tongue and/or facial skin. It is possible, although rare, that the paresthesia would be permanent.
- I understand that root canal treatment is an attempt to retain a tooth that would otherwise require extraction. Although root canal treatment has a high degree of success, it cannot be guaranteed. Occasionally a tooth undergoing root canal treatment may undergo acute infection. It may require re-treatment, surgery, or (rarely) extraction.
- I understand that preparation of teeth for crowns, bridges, and fillings may, on occasion, traumatize the pulp (nerve). If the pulp (nerve) is in a weakened condition, this may necessitate a root canal treatment on that tooth in the future.
- I realize that dental insurance policies restrict payment for some services, use restricted fee schedules (called usual and customary rates) and exclude some procedures based on prior conditions or length of time on plan. Posterior teeth may be paid for at "silver" or amalgam filling rate. All restrictions are based on the premium paid for insurance and not our fees or recommended treatment.
- Women taking birth control pills should be aware that antibiotics, such as penicillin or erythromycin, could possibly counteract the effects of the pill and you could become pregnant.
- I realize that any of the work that the doctor proposes can be performed by a specialist. I will tell the doctor or his staff if I desire that a specialist perform the work.
- I **DO / DO NOT** (circle one) grant permission to take photographs of my mouth or head and neck to used, without revealing my identity, for the furthering of medical and dental knowledge and education.
- I understand that if I fail to give a 48 hour notice to cancel a scheduled appointment I can be charged a fee up to the amount of the scheduled appointment procedure, I also understand that any X-rays taken are property of the dentist, and that a fee may be charged for any duplication or transfer of said X-rays. I have not taken any mood or mind altering drugs prior to signing this form.

Date_____ Signature_____