The Smile Studio
A FAMILY DENTISTRY

Thank you for selecting our dental healthcare team

We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us –we will be happy to help.

Consent for Treatment

1 I hereby authorize doctor or designated staff of the Smile Studio to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____ 's dental needs.

2 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.

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 ask for a complete recital of any 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. In the event payments are not received by agreed

Patient's Signature _____ Date _____ Witness _____

Parent/Responsible Party's Signature _____

Relationship to Patient _____