

**CONSENT**

The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patients, dental needs. I also, authorize the Doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) \_\_\_\_\_, I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment. Lastly, I understand that all responsibility for dental services provided in this office for myself or my dependents are mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account. By signing below, I understand and agree that in the event of default, I am legally liable for all costs of collection including collection fees, reasonable attorney fees, court costs, and all other costs related to the collection of this debt.

Patient \_\_\_\_\_ Date \_\_\_\_\_  
Parent or Responsible Party \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Witness \_\_\_\_\_ Date \_\_\_\_\_

**Authorization and Release**

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service.

**PLEASE NOTE: PREMIER DENTAL CENTER IS NOT RESPONSIBLE FOR KNOWING YOUR INSURANCE BENEFITS IN DETAIL. OUR ESTIMATES ARE STRICTLY ESTIMATES!**

X \_\_\_\_\_  
Patient signature and/or financially responsible party (parent/guardian if minor)