Beautiful Smiles

1. I hereby authorize doctor or designated staff to take x-rays, study models, photography, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my 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. I understand that there have been no guarantees given or implied of any sort by anyone as to the results that may be obtained.
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 give consent to the doctors or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carry out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

Name (Please Print):_____ Date:_____

Signature:_____

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