PATIENT CONSENT

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I understand that I may withdraw or revoke my authorization at any time. I may revoke this authorization by notifying my practice in writing.

I understand that by signing this Consent form, I am giving my consent to disclose and discuss my protected health information to carry out treatment, payment activities and health care operations.

The undersigned hereby authorizes the dentist to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis of the patient's dental needs. I also authorize the dentist to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand, and agree to the above terms and conditions.

Patient Signature

Date