The undersigned hereby authorizes the Doctor to take X-rays, study models, photography, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medications and therapy that may be indicated. I also understand the use anesthetic agent embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained.

Patient Name:____

Patient Signature: ______________________________________
(Parent of child)

Date: ________________________

Dentist Signature: ____