

CONSENT FOR TREATMENT

Please read the following carefully, initial and sign where applicable.

_____ I _____ hereby authorize Dr. Glasband and/ or staff to take x-rays, study models, photographs, and other diagnostic aids recommended by doctor to make a thorough dental diagnosis.

_____ Upon diagnosis, I authorize Dr. Glasband to perform all recommended treatment mutually agreed upon by me as required to provide proper care.

_____ 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 explanation of any possible complications.

_____ I give consent to Dr. Glasband and/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 carrying 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.

_____ I agree that I am responsible for full 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.

Patient's Signature

Date

Parent/Guardian's Signature

Relationship to Patient