

Account Information

Person Financially Accountable for Account

Name (Last, First, MI)
Relationship to Patient
Social Security Number
Address
City/State/Zip
Phone

You

Name (Last, First, MI)
Occupation
Employer's Name
Address
City
Phone
Fax

Your Spouse

Name (Last, First, MI)
Occupation
Employer's Name
Address
City
Phone
Fax

Consent for Treatment

- 1. I hereby authorize Dr. Keyser or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by Dr. Keyser to make a thorough diagnosis.
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.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using these agents and undergoing dental treatment embodies certain risks. I understand that I can ask for a complete recital of The Risks of General Dentistry.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payments due a the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature: Date:

Witness Signature:

Parent/Responsible Party's Signature:

Relationship to Patient: