CONSENT FOR TREATMENT

1. I HEREBY AUTHORIZE Dr. Eubanks, Dr. Nguyen and designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental records.

2. Upon such diagnosis, I hereby 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 anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I understand that there is a 48 hour cancellation policy. If a cancellation is made in less than 48 hours, there may be a charge for this.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due in full at time of service unless prior arrangements have been made. I understand that a claim will be submitted to my insurance carrier when applicable, however ultimate responsibility for payment is mine. I understand that a 2% finance charge is added monthly to any balance over 60 days. If required, I also understand that a credit check of my history may be made.

Patient's Signature _____

Date _____

Parent or Responsible Party's Signature _____

Relationship _____

Witness _____

Date _____