SUNRISE PEDIATRIC AND FAMILY DENTISTRY

9211 WEST ROAD SUITE 151, HOUSTON TX 77064

INFORMED CONSENT
FOR DIAGNOSTIC AND PREVENTIVE TREATMENT

Patient Name _____

I understand that I am having the following work done: exam, x-rays, dental cleaning, scaling.

I authorize the provider to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and agree this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform the office of any changes to the information I have provided. I understand that dentistry in not an exact science and that therefore reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee has been made by anyone regarding the dental treatment by which I have requested and authorized. I have had the opportunity to read this form and ask any questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

AGREEMENT:

I understand the recommended treatment for my conditions, the risks of such treatment, any alternatives and their risks as well as the consequences of doing nothing. All the fee(s) have been explained. All of my questions have been answered and I have not been given any guarantees.

Patient's signature (Parent or Guardian's Signature, if minor)

X_____ Date:_____