

**AUTHORIZATION FOR DENTAL TREATMENT**

**1** \_\_\_\_\_, hereby authorize and consent to any treatment or procedure or the administration of necessary anesthetics which my dentist deems advisable in the diagnosis and treatment of this patient. By signing this medical authorization and consent, I understand that as matter of law it shall be conclusively presumed:

**A.** That the action of my dentist in obtaining this consent form from me is in accordance with an accepted standard of dental practice among members of the dental profession similar training and experience in this or similar medical communities: and information provided to me by my dentist. I, under these circumstances, have at least a general understanding of the procedures, the medically accepted alternate procedures or treatment and the substantial risk and hazards inherent in the proposed treatment or procedures which are recognized among dentists in this or similar community who perform similar treatment or procedures.

**B.** That I, considering all surrounding circumstances, would have undergone such treatment or procedure and I been advised by my dentist as described in paragraph A. above.

**C.** I have authorized my dentist to take the necessary x-rays in order to properly diagnose my dental needs. **(With the exception of pregnancy or medical problem, x-ray will be needed).**

**D. I am responsible for the payment of the treatment that I receive at each visit. If I have dental insurance I will disclose all necessary information and I will be responsible for any balance(s) that will remain from my insurance.**

**E.** I authorize treatment for my child that is a minor (mother, father, or guardian).

**F.** I am responsible for 100% payment of any lab work (crowns, partials, or dentures). **If I neglect to pick up my lab work/case at the appropriate time this is still my financial responsibility.**

**G.** It is our desire to communicate to you that we are taking the new federal (**HIPPA**-Health Insurance Portability and Accountability) laws written to protect the confidentiality of your health information seriously.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
**Guardian**