

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment, mutually agreed upon by me, and to employ such assistance as required providing 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 agree to be responsible for 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. In the event payments are not received by agreed upon dates, I understand that a 1-½% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.
5. I hereby give Ellis K. List, DDS, PA the absolute right and permission to use my photographs for educational or promotional purposes. The undersigned completely and forever releases any right to present or future compensation in connection with the use of said photographs.

Patient's signature _____ Date _____

Witness _____ Date _____

Parent/Responsible Party's Signature _____

Relationship to Patient _____