Banana River DENTAL

CONSENT FOR TREATMENT

1.) I hereby authorize the treating doctor or designated team member, to take radiographs (x-rays), study models, photographs and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of
(name of patient) _____'s dental needs.

2) Upon such diagnosis, I authorize the treating doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. This may also lead to referral to a specialist in another field if the treating doctor feels the treatment needed of outside the scope of their training.

3) I agree to the use of Local Anesthetics, hemostatic agents and any other medication as necessary. I fully understand that using such medication, including local anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4) Lastly, 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 I can be turned over to a collection agency.

Patient Signature:_____*Date*:_____

PHOTO RELEASE

I agree to allow Banana River Dental to use photographs and/or videos (which may or may not include full facial views), models and/or descriptions of my case, for consultation, educational, presentation and/or social media/promotional purposes. This release covers all photographs taken prior to, and after, the date of this release.

Patient Name: (please print) _____

Patient Signature:_____*Date*:_____