WATERS FAMILY DENTISTRY

CONSENT FOR TREATMENT AND ASSIGNMENT

I hereby voluntarily consent to examination and treatment as a patient, included but not limited to the administration, performance and cost of dental and medical care, treatment, surgical or diagnostic procedures, x-rays and medication that the dentist treating me and/or my dependents/representees deems necessary under the circumstances.

I hereby voluntarily assign the authorized payment directly to Waters Family Dentistry from my insurance company or any other source for all benefits otherwise payable to me.

_____

Patient Name (Please Print)

_____ _____

Patient Signature Date

OR

_____

Name of Personal Representative

_____ _____

Signature of Personal Representative Date

Authority of Personal Representative to Sign for Patient (check one):

___Parent ___Guardian __Power of Attorney __Other: _____

Dental Office Use Only

Signature was not obtained due to:

___An emergency prevented us from obtaining signature.

___A communication barrier prevented us from obtaining signature.

___The individual was unwilling to sign.

___Other: _____

_____ _____

Staff Member Signature Date