

Consent for Services

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs.
2. Upon such diagnosis, I authorize the doctor to perform all recommend treatment mutually agreed upon and to employ such assistance as required to provide proper care. I realize there are inherent risks in dental restorative treatment, and I understand I have the opportunity to ask any questions appropriate for my care.
3. I agree to the use of anesthetics, sedatives and other medications 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 that the practice of dentistry is not an exact science; no guarantees or assurance as to the outcome of treatment can be made due to the uniqueness of every individual clinical situation. Every effort is made to achieve a mutually satisfactory result.
5. 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.
6. I agree that my signature below may act as a "Signature on File" for credit card transactions authorized by phone on behalf of myself and my family members.
7. I agree that when insurance is billed on my behalf either by paper claim or electronically that "Signature on File" is acceptable.
8. I provide consent to Robillard Dental to use my cell phone number to call or text regarding appointments.

Date

Print Name

Signature of Patient/Guardian

Date

Print Name

Signature of Witness