

1. I authorize the doctor or designated staff to take x-rays and/or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of

\_\_\_\_\_’s dental needs.

2. Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics and/or other medications as necessary. I fully understand that utilizing anesthetics entails certain risks. I understand that I can ask for a complete description of any possible complications.

4. I understand that Peterson Family Dentistry can file claims to insurance and co-ordinate benefits as a courtesy to me. Estimates of my deductible and the portion not covered by insurance will be provided, but the estimates may be different than my insurance company’s calculations. Therefore, the amount due to the office may be adjusted accordingly. I understand it is my responsibility to be familiar with the benefits and limitations of any insurance coverage. The patient is ultimately responsible for the account and that of their dependents regardless of insurance coverage.

5. I agree to keep my reserved dental appointments. If I must cancel an appointment I agree to give 24 hours advanced notice whenever possible and understand that there may be a fee for repeated broken appointments.

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Signature

Date