

jeopardize my oral health and put myself at risk. I will be financially and personally responsible for such risks and subsequent results.

- 6) My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff. I am responsible for clarifying any aspect of my treatment that I am unsure about.**
- 7) Upon such diagnosis, I authorize the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care.**
- 8) I agree to use the 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.**
- 9) I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at time of service.**

NAME: _____

RELATIONSHIP TO THE PATIENT: _____

SIGNATURE: _____

DATE: _____