

# Dr. Jacob Berger, D.D.S.

*Family and Cosmetic Dentistry*

## PATIENT CONSENT FORM

- I. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
- II. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medications and therapy indicated for such treatment in connection with (name of patient) \_\_\_\_\_, I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
- III. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time of services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates. I understand that a 1.5% finance charge (18% APR) may be added to my account, in addition to any collection charges.
- IV. I understand that where appropriate, credit bureau reports may be obtained.
- V. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

**PATIENT:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**WITNESS:** \_\_\_\_\_

**PARENT OR RESPONSIBLE PARTY:** \_\_\_\_\_

**RELATIONSHIP TO PATIENT:** \_\_\_\_\_