



Consent for Treatment

I authorize and give consent to the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of patient's dental needs.

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

I agree to the use of 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.

If I am a female using oral contraceptives, I understand that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, I understand that I will need to use some additional form of birth control, during the use of antibiotics and for one complete cycle to birth control pills after the antibiotics are completed.

I consent to the proper disposal of any tissues or body parts that may be removed (e.g., tooth, mercury filling material, blood).

I grant my permission to the doctor, agents, assigns to telephone me at my home or at my workplace to discuss matters related to this consent, my treatment, or my account.

I hereby authorize Donald K. Meyer DDS PC to release any information necessary to process my family's dental claims.

Signature of Patient, Parent or Guardian

Date

(Print) Patient Name