CONSENT OF TREATMENT for_____

1. I hereby authorize doctor or designated team members to take X-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.
2. Upon such diagnosis, I authorize and request 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, sedatives and other medication as necessary. I fully understand that using agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. 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, regardless of insurance coverage. In the event payments are not received by agreed dates, I understand that a $30.00 late charge may be added to my account.
5. I understand that Dr. Rojas does not participate in any insurance plans. Our office will provide you with the necessary forms and information to assist you with the claim. Any payment from your insurance company will be directed to your mailing address.
6. I understand that any appointment cancellations made less than 24 hours in advance will result in a fee of $50.00 for which I am responsible.
7. To the best of my knowledge the information provided on these forms is accurate and truthful. If you had difficult reading or understanding any of these questions, please make this known to the dentist.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

_____ _____

Parent/Responsible Party Date

3400 S. Tamiami Trail, Suite 301 • Sarasota, FL 34239
941-951-7711