

Smiling Faces Pediatric Dentistry

Frank R. Faunce, D.D.S.

302 Stevens Entry

Peachtree City, Georgia 30269

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TREATMENT CONSENT

Patient's Name: _____
(first) (middle) (last)

I, being the parent or legal guardian of the above named minor patient, do hereby authorize and request performance of dental services for me (this patient) and the use of whatever procedures Dr. Frank R. Faunce and such assistants as he/she may designate to treat this patient will use preventive, restorative, oral surgical, patient management and pain management techniques that are reasonable, necessary and advisable.

I agree to diagnostic procedures and dental treatments. Along with patient management techniques as found necessary by Dr. Frank R. Faunce and staff for the above named patient. I will accept responsibility for this account should named responsible party fail or insurance benefit be denied. I understand that should my account become 60 days past due, a monthly charge of 1.19% will be applied to my balance until it is paid in full. Furthermore, I understand that if my account becomes past due, all necessary steps will be taken to collect this debt. If it becomes necessary to refer my account to a collections agency, I agree to pay the collection fees that are incurred.

I authorize release of this information to the patient's medical doctor of record. I also authorize the administration of anesthetics or analgesics which may be deemed advisable by Dr. Frank R. Faunce. I understand that the treatment plan to be presented, along with the fees to be presented, could change depending upon the time lapsed since the initial examination and the extent of dental pathology. Furthermore, by signing this, I acknowledge all questions that I may have asked have been answered to my satisfaction and I agree to be responsible for full payment of all charges for dental services performed on the above named patient.

Signature: _____ Date: _____

Relationship to Patient: _____ Current Medical Doctor: _____