Patient Consent Form

General Consent:

I understand that the information that I have provided today is correct to the best of my knowledge. I also understand that it is my responsibility to inform Laredo Covenant Dental, P.A. of any information concerning my health or physical and mental condition that may be relevant to my care and to inform any changes in any medical status.

I authorize the dental staff to perform any necessary dental services, such as x-rays, impressions, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a complete diagnosis. I also authorize the doctor (and his or her employee for assistance when applicable) to perform any and all forms of treatment, medication and therapy with my informed consent in connection with my diagnosis and treatment plan.

Financial Agreement:

Even though I carry dental insurance, I understand that I am personally responsible for the payment for services rendered. It is my understanding that payment is due at the time of service, unless other financial arrangements have been made. In the event that my insurance carrier pays less than the proposed fee, I am fully responsible for the unpaid balance.

I have read and understand the above conditions and do voluntarily consent to care and financial agreement at Laredo Covenant Dental, P.A.

Date: ______________________________

Patient's Name (Print): ______________________________________

Patient's Signature: ______________________________________

(If unable to sign, Parent or Legal Guardian)

Witness: ____