Wheaton Cosmetic Dentistry
1275 E. Butterfield Road, #202
Wheaton, IL 60189
630-653-5152
Fax - 630-653-5380

CONSENT FOR TREATMENT

1. I hearby authorize the doctor or designated staff to take x-rays, give fluoride, do study models, take photographs or any other diagnostic aids of (patient name)____

2. Upon such diagnosis, I authorize 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, sedative and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete explanation of any possible complications.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient ______________________________ Date _____________________

Parent or responsible party _______________________________________

Relationship to patient ____

Witness ____