PATIENT CONSENT FORM

The undersigned hereby authorizes Doctor (Dr. Reya Weeks) and her staff to take radiographs, study models, photographs, or any other diagnostic tools, all deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. The undersigned also authorizes Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Patient) _____. And further authorize and consent that Doctor choose and employ such assistance as she deemed fit. Patient understands that use of anesthetic agents embodies a certain risk.

I, the patient/guardian, understand that dentistry is not an exact science and that specific results cannot be assured or guaranteed. I understand that during treatment, it may be necessary to change or add procedures because of conditions discovered during the treatment that were not evident during examination. I understand and authorizes the Doctor to used her best professional judgment to provide the appropriate care even when this represents a change in the diagnosed problem and course of treatment. I acknowledge that no such guarantees have been made regarding the dental treatment to be performed. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment.

I truthfully revealed all aspects of my health history and I realize that failure to have done so may have negative consequences for my health and the success of my treatment. I agree to cooperate fully with the recommendations of my Dentist and Dental Hygienist and I realize that failure to do so may result in less than optimum results and compromise the life span of my treatment. I also agree to follow the recommendations for home care and the schedule for future tooth cleaning and check-ups. I realized that failure to do my part in the maintenance of my oral health will compromise the success of any dental treatment I may receive.

CONSENT: I certify that I understand fully, all the statements mentioned above.

_____ _____

Patient / Guardian Today's Date