CONSENT FOR TREATMENT

By my signature below, I hereby consent to and authorize any X-rays, examination, anesthetic, diagnosis, and treatment by Northern Lights Dental and the dentist who is treating me. I understand that dentistry, as in all medical treatments, is not an exact science and that therefore results of any treatments performed may vary from patient to patient and cannot be guaranteed. I understand that occasionally, additional treatments, or therapies may require following dental treatment and that I am granting my consent for any and all treatments, therapies, and procedures performed by Northern Lights Dental and the dentists, hygienists, or assistants of Northern Lights Dental. Also, by my signature below, I hereby certify the correctness and completeness of the medical history information which I have provided.

Privacy Practices

By my signature below, I acknowledge that I have received a copy of this office's privacy practices.

I wish to have information about my account released to the people I have listed below.

Additional people: _____

Patient signature: _____ Date: _____

Print Name: _____

Other Side