

## MEDICAL HISTORY UPDATE

DATE	CHANGES	SIGNATURE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

## AUTHORIZATION FOR TREATMENT

I hereby consent to the following dental procedures to be performed by a dentist at Randolph Dental Associates:

*Complete diagnosis and evaluation including x-rays, restorative procedures, oral surgery, or other dental procedures deemed necessary by the dentist including the administration of local anesthesia and/or nitrous oxide.*

I understand that unforeseen conditions may be encountered which will require procedures other than those contemplated. I therefore request and authorize the dentist to perform such additional procedures as he/ she may seem necessary. The nature and risk of these procedures have been explained and I understand them. I recognize that the practice of dentistry is not an exact science, and that no guarantees have been made to me as to the result of these procedures.

I hereby agree to waive and release Randolph Dental Associates, it's dentists, and employees from all claims related to treatment rendered to me as set forth in this agreement.

I understand the payment policy of Randolph Dental Associates to be:

Payment for services rendered is to be paid at the time of service unless other written arrangements were made prior. In the event this account is sent to a collection agency, a reasonable attorney's fee will be added to the account balance.

Patient signature \_\_\_\_\_

## INSURANCE AUTHORIZATION

I authorize Randolph Dental Associates to release all information necessary to secure the payment of benefits. I understand that I will be responsible for all charges whether or not paid by insurance.

Patient signature \_\_\_\_\_

## PHOTOGRAPHIC RELEASE

Photographs and x-rays may be taken during treatment, which may be necessary for ideal treatment outcomes. I consent to the release and use of this information and understand that every effort will be made to conceal my identity.

Patient signature \_\_\_\_\_