NORTHPARK DENTAL ASSOCIATES

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Diagnosis and Treatment

I hereby authorize Dr. Gibbons and/or his designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by Dr. Gibbons to make a thorough diagnosis of my dental needs.

Upon such diagnosis, I authorize Dr. Gibbons and staff to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Patient's Signature _____Date_____

Parent/ Responsible Party Signature _____

Relationship to Patient_____

BROKEN APPOINTMENTS: We strongly encourage all patients to keep their appointments. Failure to give 24 hour notice to cancel or reschedule an appointment will result in a $50 per hour charge to your account. Emergencies are the only exception. _____(Initials)

Photography Consent

I hereby give Northpark Dental Associates the absolute right and permission to use my photographs for educational or promotional purposes. The undersigned completely and forever releases any right to present or future compensation in connection with the use of said photographs.

Signature _____ Date_____