FAMILY DENTISTRY ASSOCIATES
OF JOHNSTOWN, P.C.
223 MAIN STREET
JOHNSTOWN, PENNSYLVANIA 15905

TELEPHONE (814)535-7894

CONSENT TO TREATMENT

PATIENT NAME _____

PATIENT AGE _____

1. I hereby authorize and request the above to perform dental treatment on me.

2. I also authorize and request the administration of such anesthetic, or anesthetics, as be deemed advisable by the doctor.

3. I also authorize and request the taking of such x-rays as may be deemed advisable by the doctor.

4. It has been explained to me, and I understand, that a perfect result is not guaranteed.

5. I also understand that I may be billed for failed appointments, if I have not given proper notification of 24 hours advance of the appointment.

SIGNATURE: _____

DATE: _____

Print Form