Bella Dente Fine Dentistry

13650 West Colonial Suite 120-A
Winter Garden Florida 34787
Tel: (407) 905-5698 Fax: (407) 905-0513

Patient Name: _____ Today's Date: _____

Consent:

The undersigned hereby authorizes the doctor to make x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorized the doctor to perform any and all forms of treatment, medications and therapy that may be indicated for the above named patient after being informed of the treatment recommended by the doctor

I further authorized the doctor to choose and employ such assistance as she sees fit. I also understand that the use of anesthetic agents embodies a potential risk.

I understand the responsibility for payment for all dental services and lab work provided for me and my dependents is mine; due and payable at the time that services are rendered unless prior financial arrangements have been made.

I also understand that all x-rays and diagnostic aids are the property of the dental office and that copies, if requested, will be made available to me for a reasonable fee as set by this office.

THE ABOVE INFORMATION IS TRUE AND I PROMISE TO NOTIFY THIS OFFICE OF ANY CHANGES IN MY MEDICAL HISTORY AS SOON AS THEY OCCUR.

_____ _____

Signature of Patient or Legal Guardian Date

TO BE COMPLETED BY THE DENTIST

Medical Summary:

_____

_____

Medical Alert:

_____

_____

Medical Clearance required: YES ( ) NO ( )

Patient must be pre-medicated YES ( ) NO ( )

Penicillin _____ Erythromycin _____

Date Reviewed: _____ Dentist's Signature: _____

Date Reviewed: _____ Dentist's Signature: _____

Date Reviewed: _____ Dentist's Signature: _____

Date Reviewed: _____ Dentist's Signature: _____