1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient)_____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. 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.
4. Lastly, I agree to be responsible to payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18%APR) maybe be added to my account.

Patient_____Date_____Witness_____

Parent or Responsible Party_____Relationship to Patient_____

KNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,(print)_____**have received a copy of this office's Notice of Privacy Practices.**

_____ _____
Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET

I,(print)_____**have received A copy of the Dental Materials Fact Sheet dated October 2001 from Curtis E. Jansen, D.D.S.**

_____ _____
Signature Date

INFORMED CONSENT