



R. BROOKS LEGG, JR., D.D.S.

LYDIA R. LEGG, D.D.S.

CONSENT FOR TREATMENT

1. I hereby authorize the dentist or designated staff to take x-rays, study models photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my or the patient's dental needs.
2. Upon such diagnosis, I authorize the dentist 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. I agree to be responsible for payment of all services rendered on my behalf or the patient. I understand that payment is due at the time of services unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 1/2% late charge (18% APR) may be added to my account.
5. In the event I can not bring my child for his/her dental visits, I give _____ permission to bring them for all dental work.

Patient's Name

Patient/Guardian's Signature

Relationship to Patient

Date