

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 1.5% late charge (18% APR) maybe be added to my account.

Patient _____ Date _____ Witness _____

Parent/Responsible Party _____ Relationship to Patient _____

**ACKNOWLEDGEMENT OF RECEIPT OF
HIPPA NOTICE OF PRIVACY PRACTICES**

I, (print) _____ have received
a copy of this office's HIPPA 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