Patient Name______________________________DOB______________

I, ______________________________________ (______________) give my permission for
Relationship to patient

Dr Hagler / Dr Sciarrilla and Staff to provide all Dental treatment without me being present at scheduled appointments from this date forward.

My signature is giving my informed consent for necessary dental treatment.
I give my consent to the attending dentist to render dental treatment and I am aware that the payment for services is due at the time they are rendered.
I recognize that failures can occur for all kinds of reasons and that complications can occur in any procedure. I also understand that, where decay has occurred, or a tooth has fractured or abscesed, that these same forces are still working on the tooth even after it has been resotred: therefore, decay or fracture can still occur as the restored tooth is no better than what nature has given in the first place. I also acknowledge that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. If for any reason a confilct or disagreement should arise I will first present such conflict or disagreement to my attending dentist in order to resolve the problem. If we are unable to agree on a solution, then I agree to take the problem to a reconcilliation/mediation board such as the dental society and agree to accept their resolutin in lieu of pursuing remedies by way of litigation. I also understand that this agreement is binding on their heirs and all other family members.

______________________________________ ______________
Signature Date

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Contact ph #'s