Steven R. Zembroski, DMD

Cosmetic and Family Dental

Consent Agreement

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.

2. If further information is needed you have my permission to ask the respective health care provider or agency, who may release such information to you.

3. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

4. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.

5. Dr. Zembroski is involved with educational programs and training. Your assistance in allowing him to document your case will benefit other patients.

   I do I do not consent to the use of my x-rays, records, and photographs for demonstration, scientific teaching or research purposes. Your identity will be kept confidential

   I do I do not consent to the use of such records for demonstration to other patients, promotion of services or advertising. Your identity will be kept confidential.

6. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at the time of service unless other arrangements have been made.

_____ _____

Patient or legally authorized individual signature Date

_____ _____ _____

Printed Name if signed on behalf of patient Relationship (parent,etc) Patient Name