BRIGHTEN YOUR SMILE
DENTISTRY

Dr. Keith Shepard

Consent

1. The undersigned hereby authorize the doctor(s) and or staff of Brighten Your Smile Dentistry to perform dental treatment ,dental operation, diagnostics, test, or any other procedure deemed necessary or appropriate by the doctor(s) to make a thorough diagnosis of the patient's (named on opposite page) dental needs.

2. Upon such diagnosis, I authorize Brighten Your Smile Dentistry to perform all recommended treatment mutually agreed upon by me and employ such assistance as required to provide proper care.

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

4. I authorize my insurance benefits to be paid directly to Keith Shepard DDS, PC and I authorize the release of any information required. I understand that Brighten Your Smile Dentistry will file my insurance claim as a service to me, but I am responsible for all amounts not paid by the insurance company for any reason. I will be expected to remit payment in full. I further understand that a finance charge (currently 18.0% A.P.R) will be added to any overdue balance. If collection and/or legal services are required to obtain payment of the amount billed, I further agree to pay for legal fees and costs reasonably incurred.

_____
Print Patient Name

_____
Patient Signature (Parent/Guardian for patient under 18)

_____
Print Parent/Guardian Name (for patients under 18 ONLY)

_____
Parent/Guardian Relationship (for patients under 18 ONLY)

_____
Date

EMEGENCY CONTACT
In case of an emergency please contact:
Name:_____

Phone #:_____

KEITH SHEPARD, DDS PC
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