
CONSENT FOR TREATMENT

1. I hereby authorize Dr. Nibouar, Dr. Baran or designated staff at Limestone Dental Associates to take x-rays, models, photographs, and any other diagnostic aids deemed appropriate to make a thorough diagnosis of
   (name of patient) _____ 's dental needs.

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

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

4. Lastly, I agree to be responsible for 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.

Patient _____ Date _____

Parent or responsible party _____

Relationship to Patient _____