LOWMAN FAMILY DENTAL
PO Box 292
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Holmen, WI 54636-5000

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Patient Name:

Last First MI Preferred Name

DENTAL TREATMENT CONSENT

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.
2. 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.
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. I realize that it is mandatory that I give accurate, and complete medical and personal history; follow any instruction; and permit prescribed diagnostic procedures.

If patient is a minor under the age of 18, please read & complete the following section;

The undersigned, parent/guardian of the minor, hereby consents to the provision of dental care and treatment to the minor with or without parent/guardian present by Lowman Family Dental. The undersigned parent/guardian also agrees to be fully responsible for the payment of all charges for such dental treatment and agrees to pay for the treatment in accordance with the policies of Lowman Family Dental.

*This consent is ongoing and shall remain in effect until revoked in writing by the undersigned. The undersigned also represents and warrants to Lowman Family Dental that such parent/guardian is empowered to consent to this dental treatment and is not subject to any court order regarding the care or custody of the minor child, which would require the consent of any other parent or any third person, including any guardian or health-care representative.

____(Check only if applicable) The undersigned is the guardian/health care representative of the minor child listed above and has been appointed pursuant to i.c. 16-36 and attaches a copy of the document establishing such power. The guardian consents to the treatment checked above and agrees to be fully responsible for payment of all charges.

I have had full opportunity to read and consider the contents of this consent. I understand that, by signing this form, I am confirming my written permission for the disclosure of my protected health information, and for treatment, as described in this form. This consent will remain in effect until cancelled in writing by me.

Signature: _____ Date:

If this consent is signed by a personal representative/ parent on behalf of the individual, complete the following.
Person Representative's/ Parent's Name, and Relationship to Individual.

Response Date: