LOUNON MOBILE DENTAL CARE

DR. ROBERT D'EMIDIO

CONSENT FORM FOR TREATMENT

DATE:_____

I,_____, GIVE MY CONSENT TO THE MOBILE DENTAL CARE (DR. ROB D'EMIDIO) TO PROVIDE DENTAL TREATMENT AS NEEDED TO

_____.

I UNDERSTAND THAT I AM RESPONSIBLE FOR THE PAYMENT FOR THE DENTAL TREATMENT PROVIDED.

PLEASE SEND THE BILL FOR THE DENTAL SERVICES PROVIDED TO:

Name:

Address:

SIGNATURE:_____

RELATIONSHIP TO PATIENT:_____

PLEASE NOTE: IN THE MAJORITY OF CASES, TREATMENT AND TREATMENT COSTS WILL BE DISCUSSED WITH THE RESIDENT AND FAMILY PRIOR TO TREATMENT RENDERED. THERE ARE RARE OCCASIONS DURING DENTAL PROCEDURES THAT AN ALTERNATIVE TREATMENT IS NECESSARY DUE TO CIRCUMSTANCES INVOLVING THE CONDITION OF THE TOOTH UNDERGOING TREATMENT.