Dr. John F. Ceraso
Carolina Center for Cosmetic and Implant Dentistry

CONSENT FOR TREATMENT

1. I _____ authorize the doctor or designated staff member 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. Upon such diagnosis, I authorize the doctor to perform recommended treatment mutually agreed upon and to employ such assistance required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medications necessary. I fully understand that using anesthetic agents embodies certain risks. I also understand that I can ask for a complete recital of any possible complications.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or on my dependents. I understand that payment is due at the time of service, unless other arrangements have been made. In the event payment is not recieved by the agreed date, a 1.5% late charge (18% APR) may be added to my account.

Patient _____Date_____

Parent or Responsible Party _____

Relationship _____