ASHLEY LLOYD, D.D.S., P.L.L.C.
1330 ST. MARY'S STREET, B-30
RALEIGH, NC 27605

CONSENT FOR TREATMENT

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (name of patient)_____, and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand that use of anesthetic agents embodies a certain risk. I understand the responsibility for payment for Dental Services provided in this office for myself or my dependents, is mine, due and payable at time services are rendered unless financial arrangements have been made. I further understand that a 1.5 % (18% annually) may be added to any balance over 60 days.

Patient_____Date_____Witness_____

Responsible Party for Minor Patient_____

Relationship to Patient_____

For use with additional procedures

I, the undersigned hereby attest to having been informed of and to understanding the risks, consequences and complications that may result from _____ procedure. All of my questions have been answered and I understand the options. Information for this procedure was provided both verbally and in written form.

Patient_____Date_____Witness_____

I, the undersigned hereby attest to having been informed of and to understanding the risks, consequences and complications that may result from _____ procedure. All of my questions have been answered and I understand the options. Information for this procedure was provided both verbally and in written form.

Patient_____Date_____Witness_____