David W. Handelsman, DDS
115-F Cathedral Street
Annapolis, Maryland 21401

Washington 301-261-2040 | Annapolis 410-268-3347 | Fax 410-268-4143

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of patient's needs.

2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with ________________________(patient name) understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.

3. I understand that the responsibility for payment for dental services provided in this office for myself or my dependants is mine, due and payable at the time of service unless other arrangements have been made. In the event that payments are not received by the agreed upon dates, I understand that 1½% finance charge (18%APR) may be added to my account, in addition to any charges incurred by the doctor to collect this debt.

4. I understand that where appropriate, credit bureau reports may be obtained.

5. I understand that it is my responsibility to advise our office of any changes to information relating to medical history as well as personal contact information and insurance information.

6. Failure to notify this office of your inability to attend a scheduled appointment less than 24 hours in advance of that appointment may result in a missed appointment fee of $60 for each hour for which the appointment was scheduled.

7. Failure to use proper antibiotic premedication as directed by doctor that requires the appointment to be rescheduled may cause a missed appointment fee to be charged.

Patient Name:______________________________ Date: _________________________________