American Family Dental Care
Implant Center
Family & cosmetic Dentistry

CONSENT FOR TREATMENT

American Family Dental care

Dr. Ayesan Hemati & Associates

1. I here by authorize doctor or designated staff to take X-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a through diagnosis of _____ dental needs.
   (Patient Name)

2. Upon such diagnosis I authorize doctor to perform all recommended treatment mutually agreed upon by me and employ such assistance as required into provide proper care.

3. I agree to the use of anesthetics sedatives and other medication as necessary I fully understand that anesthetic agents embody certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge fee (18%APR) maybe added to my account. If required, I also understand a check of my credit history maybe made.

Patient`s Signature: _____ Date: _____

Parent/ Responsible Party`s Signature: _____

Relationship to Patient: _____