JOSEPH M. CROW, D.M.D, P.C.
Family Dentistry
4634 Bit & Spur Road
Mobile, AL 36608

# GENERAL CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient)_____'s dental health needs.

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

3. 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 20% charge may be added to my account.

Patient Signature _____Date_____Witness_____

Parent/Guardian Signature_____ Relationship To Patient_____