ALL SMILES
ORTHODONTICS

Consent for Services

I hereby authorize All Smiles Orthodontics to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of dental need. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

It is recommended that all orthodontic patients get routine 6 month examinations and cleanings during treatment. If necessary, we will advise more frequent cleanings in order to monitor and maintain the patient's home plaque control.

I further understand that a $25 broken appointment fee will apply if I fail to give 48-hours advance notice to reschedule or do not show up for an appointment for any dependants or myself. In addition, I understand that any request for duplication of x-rays or charts is subject to a $20 service fee.

We allow a 10 minute grace period for all the appointments. If you are more than 10 minutes late to your appointment it is at the offices discretion as to whether or not you will need to reschedule your appointment.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian_____ Date: _____