Welcome! So that we may provide you with the best possible care please print and fill out this dental treatment consent form. Bring your completed consent form to your next appointment. All information is completely confidential.

GLENN L. SPERBECK D.D.S., INC.
HEALTH CENTERED DENTISTRY

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Westchester, CA 90045-3818

CONSENT FOR TREATMENT

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

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 the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies 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 1-1/2%, late charge (18% APR) may be added to my account.

Patient _____Date _____ Witness_____

Parent or Responsible Party _____

Relationship to Patient _____