Jackson Creek Dental Group
Smiles for Life

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CONSENT FOR TREATMENT

❑ Yes ❑ No I authorize necessary x-rays, study models, photographs and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.

❑ Yes ❑ No I authorize the doctors of Jackson Creek Dental Group to perform all recommended treatment mutually agreed upon by me. I authorize the use of appropriate anesthetics and medicines indicated for such treatment.

❑ Yes ❑ No I will ask questions to understand the consequences of NOT having the needed dental work done.

❑ Yes ❑ No I have received a copy of the financial and appointment policy. I understand and accept these office policies.

❑ Yes ❑ No I am aware that the office "Notice of Privacy Practices" is posted and is available in the reception room.

❑ Yes ❑ No I authorize Jackson Creek Dental Group to discuss my medical condition with:

_____ _____
Name *Relationship*

I authorize Jackson Creek Dental Group to leave a detailed medical message on my:

❑ Yes ❑ No **Cell phone**

❑ Yes ❑ No **On my email**

❑ Yes ❑ No **Answering machine at home**

❑ Yes ❑ No **Place of employment**

Patient Name: _____
(Please Print)

Signature: _____ Date: _____
(Parent's Signature if Patient is a Minor)