John O'Horo D.M.D., PC

GENERAL INFORMED CONSENT

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine; due and payable at the time of services are rendered unless financial arrangements have been made. I also assign all insurance benefits to the Doctor.

Patient Name: **(please print)**_____

Parent or Authorized Representative: (if applicable) _____

Signature:_____Date:_____