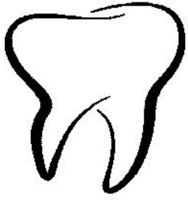

ANNETTE C. THEOFILOS, D.M.D.

CONSENT FORM

The undersigned authorizes Dr.Theofilos to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Theofilos to make a thorough diagnosis of the patient's dental needs. I also authorize Dr.Theofilos to perform any and all forms of treatment, medication and therapy, that may be indicted in connection with (name of patient) ____________________ and further authorize and consent that Dr. Theofilos choose and employ such assistance as she seems fit. I also understand payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. In the event of default I (we) promise to pay legal interest on the indebtness, together with such collection costs and reasonable attorney fees as may be required to effect collection of the note.

Patient________________________________Date___________witness_____

Parent/responsible party____

Relation to patient ____