Consent Form

I hereby authorize, for the patient named below, examination and treatment by members and employees of Shoal Creek Pediatric Dentistry, LLC and any assistants or designees deemed necessary by Dr. Thomas. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations in this office.

Release of Information

I authorize the release of information concerning this office visit to the primary care physician, family physician, referring physician or dentist.

Photographs

I authorize the taking of a digital photograph of my child for his/her dental file.

Assignment of Benefits and Guarantee of Payment

I hereby authorize payment of third-party benefits, otherwise payable to me directly to Shoal Creek Pediatric Dentistry, LLC not to exceed this offices regular charges. I understand that I am financially responsible to Shoal Creek Pediatric Dentistry, LLC for the above named patient and I agree to pay Shoal Creek Pediatric Dentistry, LLC all amounts incurred by the below named patient not covered by a third party payer within 30 days as bills are presented if arrangements have not been made with this office.

Patients Name:_____ Patients's Date of Birth:___/___/____

_____ _____

Parent / Guardian Signature Printed Name

_____/_____/_____

Today's Date