RDA Roeser Dental Associates, P.C.

CONSENT AND AGREEMENT

Patient Name: ________________________________ Date: ____________________

Please read the following information carefully so that you will understand the office policies under which patients are treated in our office. At the bottom of the page, place your signature indicating that you understand these policies and that you give permission for necessary treatment.

1. All patient records and diagnostic aids such as x-ray films are the property of Roeser Dental Associates, P.C.
2. Fees will be assessed for diagnosis, treatment, consultation, and other dental services. The policy relating to payment should be discussed before treatment is initiated.
3. Failure to keep appointments without 24 hour advanced notice or excessive cancellations for whatever reason could result in the discontinuation of treatment.
4. Our staff will answer any questions about this consent and agreement form that are not clear.

I hearby give consent to Jeffery L. Roeser, D.D.S., Douglas L. Roeser, D.D.S., and/or such persons as he may appoint, to perform on

______myself, ______my son, _____my daughter, _____my ward,

those dental procedures and treatments, including local anesthesia and/or Nitrous Oxide/Oxygen relative analgesia, which are deemed necessary. I have been informed there are some risks inherent in all dental procedures including the administration of local anesthesia and in the administration of drugs common to dental practice. Further, I certify that I understand and accept the conditions set forth above. I also understand I am free to ask any questions regarding the procedures and risks involved.

This authorization will remain in effect until cancelled in writing by me.

______________________	________________________	____________
Witness	Signature of Patient, Parent or Guardian	Date