

1. I hereby authorize Dr. J. Silberman, Dr. A. Silberman, or designated staff to take x-rays, impressions for study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient) \_\_\_\_\_'s needs.
2. Upon such diagnosis, I authorize Dr. J. Silberman or Dr. A. Silberman to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. There is a fee of \$55 per appointment hour for any missed appointment and/or cancelled appointment with less than 48 hours notice.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made in advance.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Responsible Party \_\_\_\_\_

Relationship to Patient \_\_\_\_\_