George Family Dentistry
Consents and Authorizations

Consent for Treatment

I hereby request and authorize the doctor and staff at George Family Dentistry to perform necessary dental services for myself, or my child, including but not limited to X-rays, and administration of anesthetic which are deemed advisable by the doctor.
Signature____Date_____________

Authorizations

I give the dental practice the absolute right and permission to use, copyright and publish images, film or photographic portraits of me, or those in which I may be included in whole or in part, or composite in form or character or reproductions therefore in color or otherwise made through any media, for patient education, art, advertising, trade or any other lawful purpose. Examples include, but not limited to, before and after pictures and promotions.

Signature____Date________________

Acknowledgment of Privacy Practices

I, have received and/or reviewed a copy of George Family Dentistry's Notice of Privacy Practices.

Printed
Name____

Signature____Date_________________

What is the best way to contact you?

_____Phone (____home _____Cell _____work) _____Text _____Email

May we leave a message on your answering machine or voicemail?

_____Yes _____No

May we leave a message with a member of your family? _____Yes _____No

May we text and/or email you appointment reminders and /or confirmations?
____Yes ____No