Responsibility And Consent to Treatment

I hereby authorize and request the performance of dental services for myself or for:

____ Age:__________________

____ Age:__________________

____ Age:__________________

____ Age:__________________

I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by Dr. Perrott or by supervised staff for diagnostic purposes or dental treatment.

I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage.

____ ____________________

(Signature of responsible party) (Date)

____ ____________________

(Relationship to other(s) named) (Date)

Release of Prior Records

I hereby authorize and give consent to Dr. Perrott to obtain copies of my medical and dental records from current or past dentists, physicians, psychologists, hospitals and I hereby expressly authorize any dentist, physician, psychologist, hospital, or any other medical/dental care provider to release copies of my records to Dr. Perrott upon request. I also authorize any health care provider who has treated me to discuss my care and treatment with Dr. Perrott. This authorization shall be valid until withdrawn by me, in writing.

____ ____________________

(Signature of responsible party) (Date)

____ ____________________

(Relationship to other(s) named) (Date)