Chesapeake Smiles
22 88 Blue Water Blvd Suite 420
Odenton MD 21113

Consent for Treatment

I hereby authorize the Doctor and/or designated staff to take x-rays, study models, dental photographs, perform a dental examination and any other aids that are recommended by the doctor to make a thorough diagnosis of the existing dental problems and subsequently recommend a course of treatment. Once I am completely informed and have accepted the recommended comprehensive treatment as indicated, I understand the use of local anesthetics and sedative agents embodies a certain risk. A parent or guardian must accompany all patients under the age of 18. The parent or guardian must remain on site while treatment is rendered.

_____ _____

Patient/Parent or Guardian Signature Date

Consent for Communications

I give Chesapeake Smiles permission to do the following: (check all that apply)

☐ Leave appointment, Billing or Dental information on my voicemail/E-mail/Text Message

☐ Send a recall appointment reminder postcard to my home

I give Permission to share appointment, billing or dental information with the person(s) named below:

Name: _____

Acknowledgment of receipt of Notice of Privacy Practices

If you would like a copy of our Privacy Practices please tell a member of our staff, it is posted on the clipboard. Please sign below to acknowledge that you have received or been offered a copy of the NOTICE OF PRIVACY PRACTICES with an effective date of November 2, 2009

_____ _____

Patient/Parent or Guardian Signature Date

Once an appointment is made, please remember this time has been reserved for you. A minimum charge will be made for failed appointments without prior notification within 24 hours. Please review the cancellation policy of the office. This fee covers only a portion of the overhead such as salaries, electricity, rent, etc. which still must be paid whether you are present or not.